BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

THE SOCIAL NEEDS OF CARCINOMA PATIENTS AS SHOWN BY A STUDY OF THE USE OF SOCIAL SERVICE, PETER BENT BRIGHAM HOSPITAL, YEAR OF 1947

A Thesis

Submitted by

Barbara Faris Valleroy

(A. B., University of Missouri, 1941)

In Partial Fulfillment of Requirements for the Degree of Master of Science in Social Service

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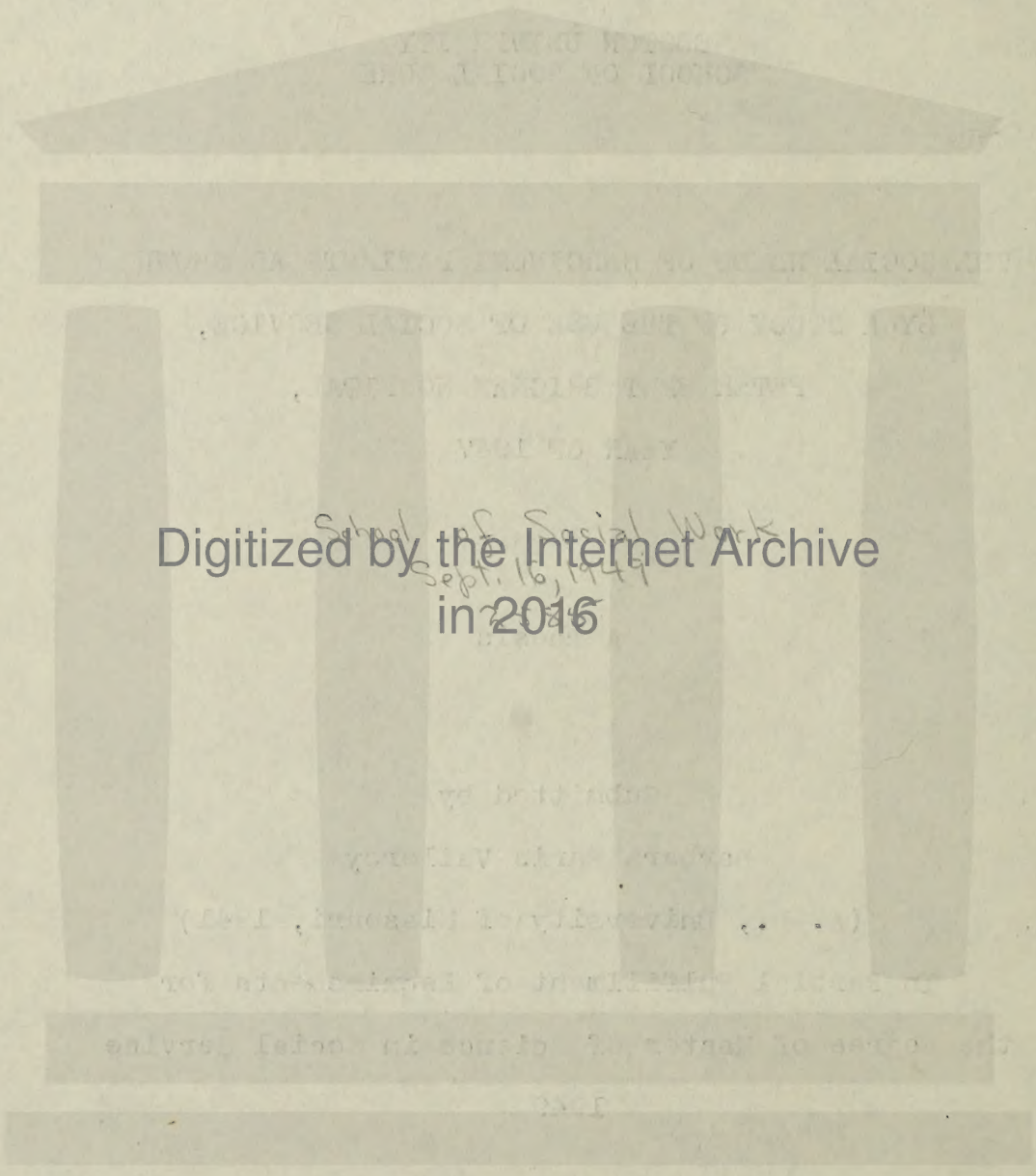

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CHAPTER I

INTRODUCTION

Exposition and Purpose

For many years medical-science publications have reported numerous studies and considerations of the theories advanced regarding the causes of carcinoma and other malignant growths and the research in the development of methods of diagnosis and treatment of these diseases. In this country, during comparatively recent years pamphlets, newspapers, magazines and other publication media have been utilized to educate the American public regarding the early symptoms of cancer and the importance of immediate medical consultation and treatment. In spite of the wealth of material available on various other aspects of carcinomas and other malignant growths, comparatively few articles, and, for the most part, only fragmentary portions of other publications have been devoted to the consideration of the emotional and social impacts of these diseases which are now second only to heart diseases as the cause of death in the United States and which it is estimated will occur in more thn one-fifth of the babies born today sometime before they die.[1]

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1 Dallas Johnson, Facing the Facts About Cancer, p. 4.

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The common practice of evading the use of the word cancer, the delay of many patients in consulting a physician after noting an early symptom, the evidence of fear exhibited by those patients who believe they may have cancer, and the lack of agreement among practitioners and others as to whether or not a patient should be told of the diagnosis of carcinoma are only a few of the casual observations that can be made which indicate the deep emotional feeling about this disease and all it represents. At the present time, no other one classification of maladies seems to carry with it such a widespread connotation of pain, disfigurement and death as does the word "cancer". A consideration of the realistic implications of the diagnosis of carcinoma as manifested in a concrete objective need for adequate medical care and in the problems related to the need for environmental and emotional adjustments brought about by the illness has prompted the writer to explore, in a very limited way, the social needs of carcinoma patients.

In an endeavor to arrive at conclusions concerning the nature of the needs of these patients, the writer, in a study of the records of a limited number of carcinoma patients referred to Social Service, has sought an answer to the following questions:

1. Why were these carcinoma patients referred to the social worker and, if by the doctor, with what recommendations?

2. What are the social and emotional needs as shown by a

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ations?

2. What are the social and emotional needs as shown by a

study of the social service and medical records of these carcinoma patients?

3. What factors limited the social worker's ability to meet the need for which the referral was made and the additional recognized needs of each patient?

Scope of Study, Sources of Data, and Methodology

The cases on which this study has been based are those of the patients with a diagnosis of carcinoma who were hospitalized at the Peter Bent Brigham Hospital sometime during the calendar year of 1947 and who were referred, during that year, to the social service department of that hospital either during their period of hospitalization or following it and while under the medical care of the hospital's out-patient department. During 1947, sixty-two patients with diagnoses of carcinoma were referred to the hospital's social service department. Of these sixty-two cases, fourteen were completely omitted from the study on the basis of insufficient recorded information. On some of the forty-eight cases the recorded material is sufficient for case illustration while the information available regarding a minority of these cases will lend itself solely to specific statistical use. (In all those specific cases used as illustrations fictional names have been substituted for the real names of the patients.)

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ation, this study is confined to a consideration of those patients with a malignant growth classifiable as one of the carcinomas. Throughout this writing the word cancer will be used as it is in the profession of medicine, as synonymous with the designation carcinoma. This usage is distinguished from the broad inclusion of sarcoma and other malignant conditions embraced by the lay use of the term, cancer.

The year of 1947 was chosen as a basis of case selection because of its being recent enough to reflect the current use of social service, yet far enough removed that the records would be available for study. Although, as previously stated, the criteria for case selection was that the patients had been hospitalized sometime during the year of 1947 and had been referred for social service during that period, these cases thus selected were used in their totality rather than in reference to the 1947 segment.

The use of the cases of patients hospitalized was indicated because the names of these patients were more readily accessible for diagnostic selection than those known only to the outpatient department of the hospital. Yet, the writer feels that a large enough portion of these hospitalized patients attended clinic, either prior to or following hospitalization or both, for some of the problems associated with regular clinic care to be reflected in the study as well as those problems posed by hospital confinement.

The sources of the material used in this study were the

social service case records, the social consultation sheets in house and outpatient department records, carbon copies of letters written and referral forms used by the Social Service Department, the house and outpatient department records, and, in a few instances, verbal information given by members of the Social Service Department. Since it is the practice of the Social Service Department to have complete case histories written on only comprehensive cases and those carried by students, the material on the majority of the cases studied represents a compilation of data secured from the other sources mentioned above. The medical records were used as a source of obtaining identifying factual material and of information related to the diagnoses and treatments.

The method of procedure used in this study consisted of a survey of books, pamphlets, and articles in periodicals from the fields of medicine and social work and a careful study of case record material. Scientific publications regarding carcinoma were used as a source of reference for the presentation of a consideration of the nature, the manifestations and the prevalence of the disease. References from literature pertaining to social work were used as background material for the social study. (The bibliography follows the final chapter.)

The study of the social needs of the forty-eight individual patients was made with the aid of the schedule devised for this purpose. (A copy of the schedule is included in the Appendix.) In this study, consideration was also given to the

social and emotional needs of members of each patient's family in such instances as these needs appeared to be directly related to the patient's illness.

Limitations

The group of individual cases studied and reported in this thesis includes all of those patients with the designated diagnosis which were referred to the Social Service Department in a given period of time with the omission only of those cases for which there was insufficient material. Although it is recognized that the nature of the group of individuals on which material was not available may have introduced an element of selectivity, the writer believes this to be minor compared with the factor that the group studied consisted entirely of those referred for social services. The selectivity involved in the referral by physicians, for the most part, would seemingly predispose this group to being composed of those individuals with the more obvious problems and those most closely related to medical treatment and care. The determination of the existence and establishment of the approximate degree of bias resulting from this element of selectivity as related to the social needs of this group of carcinoma patients' being representative of those of all carcinoma patients is not within the practical scope of this thesis.

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Another limitation lies in the nature and content of the

records from which the data were obtained. The social service recordings were written to serve the practical purposes of that department and the medical institution of which it is a part, and therefore, in many instances does not contain details that would be useful in such a study as this. Likewise medical records, which are the source of certain data, were written by the physicians for their specific purposes and usage.

CHAPTER II

CARCINOMA, A MALIGNANT TUMOR

A General Consideration of Malignancies, Their Nature, Etiology, and Prevalence

The usual definition of cancer is "a malignant tumor". Since this definition does little to enlighten the layman of the nature of the disease, it, therefore, seems expedient to first consider tumors and their classifications before proceeding to a consideration of malignance in general and carcinoma in particular.

Tumors, or neoplasms, as these new growths of cells are technically called, may develop in any tissue of the body. Homan[1] points out that every neoplasm resembles more or less closely some tissue or organ of the host in which it appears, but that both in appearance and arrangement, these new growths are not an exact duplication of the cells of normal tissue. There are two great classes into which tumors may be divided, the benign and the malignant. Benign tumors are local overgrowths of abnormal cells which grow in a restrained orderly manner and within a membrane. In contrast to the cells of the benign tumor, the malignant tumor resembles less closely the

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1 John Homan, A Textbook of Surgery, p. 193.

normal adult cell structure and is not confined to a localized area but grows in lawless fashion and spreads to various parts of the body. The only damaging effect of the benign tumor is considered to be the pressure caused by the expansion in size. In contrast, malignant tumors not only infiltrate between normal cells destroying them, but cells from the original malignant growth enter the blood stream and lymph vessels to lodge at distant sites and multiply to form what are called metastatic or secondary growths. Malignant growths not only cause pressure(usually more pressure than benign tumors) because of their unlimited ability to enlarge thus interfering with the normal function of organs and structures of the body, but they also destroy normal cells of the tissue in which they are located by cutting off their blood supply.

Boyd[2] points out that between the two extremes of benign and malignant, there are intermediate grades which make a line of demarcation difficult and, at times, impossible. He further states that it is not possible at present to say whether or not a benign tumor ever becomes converted into a malignant one. Although certain evidence points toward the possibility of transformation of a benign tumor into a malignant one, there remains the possibility that these tumors that have undergone a transition really have been malignant from their onset and are just entering on a period of increased activity.

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2 William Boyd, Surgical Pathology, p. 105.

Malignant growths can be classified on the basis of the type of tissue. One such classification suggested by Boyd[3] sets forth eight classes of tumors. Each of these classes include both benign and malignant neoplasms. The two most common malignant growths are the carcinomas and the sarcomas. The carcinomas are the tumors composed essentially of epithelial cells which tend to invade the lymph spaces surrounding connective tissue, and are the variety of malignant diseases most frequent in occurrence. Sarcoma is a malignant tumor of the connective or supportive tissue. Technically the term "cancer" applies only to the carcinomas, however, in common usage, the term is applied to any malignant growth.

Carcinomas, as do other malignancies, occur among the young and the old, among men and women, and among all of the several races. It does occur more frequently in the older age group. The incident rate of malignancy according to original site and type has been found to vary with age and sex. Tables I and II constructed by Dr. Morton Levin of the New York Division of Cancer Control illustrate the variance of the most frequent sites of malignancies according to sex and age.[4]

"The history of cancer might be said to have one underlying trend from the beginning to the present time--the general

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3 Boyd, op. cit., p. 109

4 Lauren V. Ackerman and others, Cancer, Diagnosis, Treatment, and Prognosis, pp. 19-20.

TABLE I

MOST FREQUENT PRIMARY LOCATIONS OF CANCER IN MALES AT VARIOUS AGES *

Age in Years	Order of Occurrence 1	2	3	4	5
0 - 4	Leukemia	Brain	Kidney	Eye	Adrenal
5 - 9	Leukemia	Brain	Hodgkin's	Kidney	Rectum
10-14	Brain	Bones	Hodgkin's	Mouth	Colon
15-19	Brain	Leukemia	Hodgkin's	Bones	Skin
20-24	Leukemia	Hodgkin's	Brain	Testes	Skin
25-29	Testes	Brain	Leukemia	Hodgkin's	Skin
30-34	Skin	Testes Colon	Brain Leukemia Hodgkin's	Rectum Stomach	Lung Lip
35-39	Skin	Colon	Brain	Stomach Lung	Testes Leukemia Hodgkin's
40-44	Skin	Lung Colon	Stomach	Brain Lip	Rectum Bladder
45-49	Skin	Lung	Colon Stomach	Brain Bladder Rectum	Leukemia Lip
50-54	Skin	Stomach Lung	Colon	Rectum Bladder	Brain
55-59	Stomach	Skin	Lung	Colon	Rectum Prostate Bladder
60-64	Stomach	Skin	Colon	Lung	Prostate
65-69	Stomach	Prostate	Skin	Colon	Rectum Lung
70-74	Prostate	Stomach	Skin	Colon	Rectum Bladder
75-79	Prostate	Skin	Stomach	Colon	Rectum Bladder
80-84	Prostate	Skin	Stomach	Colon	Rectum Bladder
85 +	Skin	Prostate	Stomach	Colon	Rectum Bladder

* Source: Compilation by Dr. Morton Levin, Division of Cancer Control, Albany, New York, from figures for the State of New York exclusive of New York City.

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15-19	Brain	Leukemia	Hodgkin's	Bones	Skin
20-24	Leukemia	Hodgkin's	Brain	Testes	Skin
25-29	Testes	Brain	Leukemia	Hodgkin's	Skin
30-34	Skin	Testes	Brain	Rectum	Lung
		Colon	Leukemia	Stomach	Lip
			Hodgkin's		
35-39	Skin	Colon	Brain	Stomach	Testes
			Lung		Leukemia
					Hodgkin's
40-44	Skin	Lung	Stomach	Brain	Rectum
		Colon		Lip	Bladder
45-49	Skin	Lung	Colon	Brain	Leukemia
			Stomach	Bladder	Lip
				Rectum	
50-54	Skin	Stomach	Colon	Rectum	Brain
		Lung		Bladder	
55-59	Stomach	Skin	Lung	Colon	Rectum
					Prostate
					Bladder
60-64	Stomach	Skin	Colon	Lung	Prostate
65-69	Stomach	Prostate	Skin	Colon	Rectum
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70-74	Prostate	Stomach	Skin	Colon	Rectum
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75-79	Prostate	Skin	Stomach	Colon	Rectum
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TABLE II

MOST FREQUENT PRIMARY LOCATIONS OF CANCER IN FEMALES AT VARIOUS AGES *

Age in Years	Order of Occurrence 1	2	3	4	5
0 - 4	Leukemia	Brain	Kidney	Eye	Bone Skin
5 - 9	Leukemia	Brain	Skin	Eye	---
10-14	Leukemia	Brain	Bone	Skin	Ovary Hodgkin's
15-19	Brain	Leukemia	Hodgkin's	Ovary	Skin Bone
20-24	Hodgkin's	Leukemia	Ovary	Skin	Breast
25-29	Breast	Cervix	Skin	Hodgkin's	Ovary Brain
30-34	Cervix	Breast	Ovary	Skin	Fundus Uteri
35-39	Breast	Cervix	Ovary	Colon	Skin Fundus Uteri
40-44	Breast	Cervix	Ovary	Colon	Skin Fundus Uteri
45-49	Breast	Cervix	Colon	Ovary Fundus Uteri	Skin
50-54	Breast	Cervix	Colon Fundus Uteri	Skin Ovary	Rectum Stomach
55-59	Breast	Cervix	Colon Fundus Uteri	Skin Ovary	Rectum Stomach
60-64	Breast	Colon	Cervix	Fundus Uteri	Skin Stomach
65-69	Breast	Colon	Stomach	Skin	Cervix Fundus Uteri
70-74	Breast	Colon	Stomach	Skin	Cervix Fundus Uteri
75-79	Breast	Colon	Stomach	Skin	Cervix Fundus Uteri
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25-29	Breast	Cervix	Skin	Hodgkin's	Bone
30-34	Cervix	Breast	Ovary	Skin	Ovary
35-39	Breast	Cervix	Ovary	Colon	Brain
40-44	Breast	Cervix	Ovary	Colon	Skin
45-49	Breast	Cervix	Colon	Ovary	Pudua Uteri
50-54	Breast	Cervix	Colon	Skin	Pudua Uteri
55-59	Breast	Cervix	Colon	Pudua Uteri	Ovary
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trend of theories relating to the causation of cancer". [5] The fundamental cause of malignant growths is yet unknown. The factual and experimental data accumulated by medical scientists during this century indicate that the pathogenesis of malignant diseases involves a complexity of "predisposing causes" including hereditary constitutional factor, intrinsic physiological or metabolic unbalance, and intrinsic chemical, physical or biological agents.

Diagnosis and Treatment

The malignancy diseases, insidious and treacherous in nature, often present no marked symptoms in their early stages and are sometimes difficult for even the specialist to diagnose. The specific sign and symptoms of malignancy vary considerably depending upon the type of the growth and its location. In general, evidences of malignancy are rapid growth of tissue, ulceration, bleeding, disturbance of function, and at a late stage, loss of strength, color, and weight. Pain, although usually intense in the terminal stages, is almost never present in an early stage.

The diagnosis of cancers involving portions of the body which can be exposed to view generally is not difficult for physicians, but cancer involving the internal organs often

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5 Geo. W. Holmes, and others, Cancer, A Manual For Practitioners, p. 1.

requires painstaking examination for positive diagnosis. Clinical diagnosis is based on the patient's history and a general physical examination supplemented by X-ray examinations and such other special examinations and tests as are indicated. Often the above-mentioned diagnostic procedure must be further supplemented by the operative diagnostic procedure called biopsy.

The primary purpose of a biopsy is to establish, with a minimum of delay and harm to the patient, an accurate diagnosis of the lesion. Late cancer may be readily recognized clinically, but the prognosis, in most cases, is hopeless in so far as cure is concerned. Early cancer offers the more hopeful prognosis but is frequently difficult for physicians to accurately diagnose by clinical examination alone. A biopsy consists of the removal of tissue from the questionable area for microscopic examination. It is a relatively simple procedure when applied to growths on the surface of the body or of the mucous membranes of some of the body cavities. When an internal site is involved, a more extensive operative procedure is necessary, and, therefore, an immediate microscopic examination of a frozen section of the tissue is usually made to aid the physicians in determining whether or not they should proceed with a radical operation. Another biopsy method, called aspiration biopsy, employes the use of a large needle attached to a syringe which, when inserted into the questionable growth, draws fragments of tissue into the needle by suction.

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There are limitations associated with the biopsy, one of which is that the small biopsy specimen may not be representative of the real lesion. The current opinion among physicians specialized in the diagnosis and treatment of malignancies regarding the possible danger of disseminating the cancer by the biopsy procedure is that the biopsy does not markedly increase the danger of dissemination over that produced by massage or excessive palpation. The limitation and dangers of the biopsy are considered to be far outweighed by the valuable information derived from the microscopic study of the cells from a given tumor. The biopsy aids not only in the determination of whether or not the growth is malignant, but an interpretation of the microscopic features of a tumor may be used as the basis of the choice of the therapeutic attack.

Currently the only three recognized and approved methods of treatment of malignant growths, used alone or in combination, are surgery, radium, and X-ray. The effectiveness of these methods depends, in large, upon the early diagnosis of the disease. Surgery was the only effective method of treatment of cancer and other active growths until the discovery of the two methods of radiation, radiation by x-rays and radiation by the use of radium. Since all three methods of treatment have certain limitations, it is now recognized that certain types and locations of malignancy are best treated by X-rays and radium whereas other types and locations are most effectively treated by surgery, while, in some cases, a combination of

treatment methods is indicated.

Surgery still holds the major place in the treatment of malignant diseases. This treatment of malignancies is directed toward a complete removal of the primary growth together with the neighboring lymphatics which drain the area in which the growth is located and a sufficient amount of surrounding tissue to insure complete eradication of the growth. One malignant cell missed by surgery, or by any other method of treatment, is enough to cause a recurrence of the disease. Although recent advances in surgery are increasing the number of locations in the body at which malignancies may be treated, there remain portions not yet accessible for treatment by surgery. Some lesion are too extensive for operative treatment. It cannot be denied that many of the surgical operations in the treatment are extensive and mutilating, but for many types of growth it is the most effective and expedient way by which the individual's life may be saved.

The effective use of X-rays or radium lies in the ability of the rays from these sources to pass through all kinds of tissue and to destroy the malignant cells with minimum effect on the normal tissue cells. The effect of X-rays upon a malignant growth varies according to the character of the cells of the growth. Several sources of references reflect the belief that the administration of X-rays probably always produces some harmful effect upon living tissue.[6]

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6 The Tumor Committee of the Connecticut State Medical Society, Cancer, A Handbook for Physicians, p. 31.

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6 The Tumor Committee of the Connecticut State Medical Society, Cancer, A Handbook for Physicians, p. 21.

Radium, the second source of radiation, used in the treatment of malignancy, is carried out by utilization of the rays given off by the metallic element itself or by radon seed, a small tube in which the radioactive gas given off continuously by radium has been collected. There are several processes by which radium is used. There are a number of variables in the sensitivity of normal cells to this means of treatment, therefore some individuals can be more safely treated by this means than other individuals.

Successful treatment by any combination thereof depends to a large extent on the initiation of the treatment when the malignancy is in such a stage that it can be completely removed or destroyed. Malignant cells vary in the rate at which they multiply, invade, and metasticize, therefore, the period in which a malignant growth may advance into a late stage varies considerably. The all-important step in the treatment of any malignant growth is early diagnosis.

The following table (Table III) compiled by the American Cancer Society shows the percentage of cases cured when treated early for carcinoma of certain sites as compared to the percentage cured when in a moderately advanced stage.[7] These statistics are based on cures that have endured for a period of five years or longer.

In the United States, cancer is currently rated second

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7 New York Cancer Committee, A Manual for High School Teachers, p. 87.

TABLE III

FIVE YEAR CURES*

Location	Stage of First Treatment	
	Early	Moderately Advanced
Skin	95 %	25 %
Breast	75 %	40 %
Uterus, Body of	75 %	25 %
Uterus, Cervix of	75 %	15 %
Lip	95 %	25 %

only to diseases of the heart, kidney, and circulatory system as a cause of death. In 1944, Vital Statistics reported 171,171 deaths from cancer in this country.[8] Many writers on the subject of malignancies point out the various inaccuracies reflected in these statistics, but it is generally assumed that cancer is underdiagnosed rather than over-diagnosed. The progressive increase in the number of reported deaths from malignant diseases is considered to be, in part, a reflection of more accurate diagnoses. Another factor influencing the rising death rate from these diseases is the increase in the

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* Registered by the American College of Surgeons through 1943.

8 New York Cancer Committee, A Manual for High School Teachers, p. 87.

TABLE III

FIVE YEAR CURES*

Location	Stage of First Treatment	
	Early	Moderately Advanced
Skin	85 %	25 %
Breast	75 %	40 %
Uterus, Body of	75 %	35 %
Uterus, Cervix of	75 %	15 %
Lip	95 %	25 %

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number of individuals reaching an advanced age, an age at which malignancies occur more frequently.

Mortality statistics, however, in addition to a certain degree of inaccuracy, do not reflect a realistic picture of the malignancy problem. Although malignant growths at some sites, including some of the less common malignant conditions, are almost always fatal, others, such as cancer of the skin, although frequent in incident, seldom are fatal.

According to Dr. Morton Levin , about 218.4 new cases of malignancy can be expected annually for each one hundred thousand of the population.[9] This estimate was based on Dr. Levin 's study to determine the number of new cases of malignancy in the various age groups in New York State in which it was estimated that ninety per cent of all cases are recorded.

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9 Ackerman, op. cit., p. 18.

CHAPTER III

EMOTIONAL AND SOCIAL ASPECTS OF CARCINOMA

Social and Emotional Implications

After having considered the nature, diagnosis, and treatment of the carcinomas, and prior to proceeding to an examination of the manifested needs of the group of patients whose records were used as a basis for this study, it seems appropriate to consider from the theoretical point of view some of the social and emotional implications of illnesses and operative procedures, particularly those related to the specific type of disease, the carcinomas. The recent trend in medicine pointing away from the treatment of a disease and toward the treatment of the individual with the disease (that is, the consideration of man in his totality) gives recognition to the interrelationship between the emotional, physical, and social adjustment of the individual. Social casework is directed toward meeting those needs of the individual which are derived from the interaction of the individual and his social environment and which precipitate a breakdown in or limit the individual's capacity for self-maintenance and social contribution.[1]

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1 Fern Lowry, "Objectives in Social Casework", The Family, 18:264, December, 1937.

Medical casework, a special field of social work which has developed in relation to the practice of medicine in hospitals and other organized programs of medical care, consists of the application of casework treatment principles toward relieving social and emotional factors that are unfavorable to the patient's satisfactory utilization and completion of medical treatment, toward removing the cause of disability when possible, or toward lessening the degree of disability when complete recovery is impossible. In considering the social and emotional implications of illnesses and operations it therefore seems pertinent to give attention to the individual capacities for dealing with the problems precipitated or intensified by illness, and to some of the implications for casework treatment.

Carcinoma is a chronic disease, and as such, has all of the implications, social and emotional, which are characteristic of these long term illnesses. In addition, carcinoma poses problems more specifically related to the nature of this disease. There seems to be no other disease prevalent today that presents a greater threat to the security, happiness, and comfort of the patient than does cancer. Among the threatening possibilities which a patient with carcinoma may face are the abrupt and painful termination of life and the radical operative and treatment procedures which often mean permanent disfigurement and disability.

For the purpose of convenience in discussion, the problems of patients with a chronic illness can be divided into three

general groups: (1) problems related to the need for physical care, (2) problems related to the need for environmental adjustments, and (3) emotional problems precipitated, reactivated, or intensified by the illness. In reality these three groups of problems are not clear cut, but , instead, they are interwoven one with the other, each affecting the others within the framework of the total individual personality.

Need For Physical Care

Cancer differs from most of the other chronic diseases in that early diagnosis and immediate treatment are of utmost importance. Not only does the patient with a malignant growth need adequate facilities for diagnosis and treatment, but to have a reasonable chance of being successfully treated, he must be diagnosed and treated early before the growth has become widely spread or metasticized.

Cancer patients frequently need hospitalization for the purpose of early diagnosis as well as for active and pallative treatment. Medical supervision is needed for an extended period. Even when the diagnosis and treatment are secured early and the prognosis is good, the patient needs follow-up care.

For the post-operative patients and for those whose conditions are untreatable, there is the need for special care outside of a hospital. These needs for physical attention

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For the post-operative patients and for those whose conditions are unbearable, there is the need for special care outside of a hospital. These needs for physical attention

range from a need for members of their household to be instructed in methods of home care and/or a need for a visiting nurse's services to the need for the services of full time nurses or the need for the patient to enter a convalescent, nursing, or terminal-care home.

Both those problems associated with the need for environmental adjustment and those problems of an emotional nature are closely related to the possible solutions for fulfilling the patient's need for physical care. As an aid to availing himself of the initial adequate medical care, the patient needs general factual knowledge regarding the significance of certain symptoms and the value of frequent physical examinations and knowledge of available resources. But the knowledge alone is not sufficient; he must be environmentally and emotionally free to use this knowledge. The medical caseworker ordinarily is not in a position to help the patient make and execute plans for an initial physical examination, but once the patient has come to the medical setting, the caseworker may be able to help the patient find at least a partial solution to obstacles of an environmental and/or an emotional nature and thus help the patient to be able to continue in treatment. Environmental manipulations and the mitigation of anxiety and guilt can facilitate the patient's redirecting his energies toward combating his disease.

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Need For Environmental Adjustment

Certain factors in the patient's environment, when unaltered, amy preclude or disastrously delay the patient's obtaining or effectively using the needed diagnostic, treatment, and nursing facilities. Financial circumstances, employment status, living arrangements, and attitudes and needs of members of the patient's household or immediate family are among the environmental areas in which a patient may need help before his need for care can be satisfactorily met.

Knowledge of the disease and the medical treatment of it seem to indicate that many patients with carcinoma would face financial problems sometime during the course of their illness. Not only may the patient, if he has been employed, face the loss of income because of his being or becoming physically unable to work, but the treatment and care of a cancer patient is expensive. Clinic and physician's fees, hospital bills, and the cost of diagnostic, treatment and pallative procedures, and medication can quickly exhaust savings. As in other chronic illnesses, the need for care of the patient with carcinoma is not limited to a temporary period, but it continues over an extended period. Fulfillment of the patient's medical needs may intensify or precipitate financial problems, or the lack of financial security may serve as a barrier to the patient's entering or continuing in treatment. In addition to the cost

Need for Environmental Adjustment

of medical care per se, there may be other associated needs, such as for transportation to clinic, housekeeping and/or nursing services, and resident care in a convalescent or nursing home, which require further financial planning if these needs are to be met.

Changes in the patient's living arrangement may be indicated in order for the environmental conditions and facilities to appropriately meet the patient's needs. He may be either temporarily or permanently unable to live alone in a rooming house or his own apartment where it would be difficult, if not impossible, for him to receive adequate care and diet. The patient may require more care than any member of his household or family is physically and emotionally able to give him. The former place of abode may be too crowded for the adequate care of the patient.

A most important part of the patient's environment is his family and any prolonged illness presents many social and emotional problems for the family as well as for the patient. When the illness is cancer, one would expect these problems to be greatly intensified by the insidious, painful, and incapacitating nature of the disease. Adequate treatment of the patient can and may be blocked or delayed by the patient's responsibility for the support of a household, the care of young children, aged parents, or incapacitated members of the family, or numerous other family obligations. The patient and his family frequently need help in planning for the meeting of

the reality need in such a way that the patient can be free to accept and carry out medical recommendations.

The attitude of members of the patient's family toward the patient and his illness and their understanding of the illness are important factors and are factors that merit consideration by the social worker who is aiding the patient and his family in planning for the patient's care. The members of the carcinoma patient's family need an opportunity to acquire an accurate understanding of the nature and implications of the disease. Such knowledge may help a member or members of the family to encourage the patient in his treatment and to care for him in the home or to aid in making arrangements for his care elsewhere. The members of the family need factual information, but they may also need help in emotionally diegesting the diagnosis and prognosis, and at the same time, to be as free as possible to assume additional responsibilities and to give the patient understanding and encouragement. Family attitudes as well as the feelings of the patient can influence the patient's attitudes toward becoming dependent. Members of the family may be beseiged by feelings of guilt and hostility and unless they are helped to work through some of these feelings, they will not be free to function effectively for their own or the patient's well-being. Members of the patient's family frequently need to be reassured by factual information regarding the curability of cancer where treated early, that it is not hereditary or contagious.

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The incurable cancer patient presents a special type of environmental problem. The terminal care of the hopelessly ill patient often exhausts the emotional, physical and financial resources of those upon whom he is dependent. The question frequently arises of whether home or institutional care can best meet the needs, physical and emotional, of the patient with terminal carcinoma. Consideration should be given to both the patient's feelings and comfort and the stability of the family.

Another possible need of carcinoma patients which merits consideration along with other social needs and which also suggests possible mitigation by environmental adjustment lies in recreational and/or vocational areas. When cancer affects certain organs of the body, the indicated procedure for successful treatment is radical operation. It is not easy for anyone who has been seriously ill to resume his former role as an adequately functioning individual, and when the patient has undergone a mutilating operation which results in physical limitations and/or limiting emotional repercussions, his readjustment is particularly difficult. For example: a person who has had all or part of his tongue or his larynx removed will need to be guided and encouraged in taking speech instructions and, in some instances, referred for vocational counseling, training and/or placement in a new occupation.

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pursuits, certain diversional therapy and appropriate redirection of interests and energies may aid in the reduction of the patient's anxieties and help them in feeling that they are maintaining some degree of independence.

Emotional Needs

Just as the physical and environmental facets of the total situation affect the emotional life of the individual patient, emotional components have a direct effect upon how the individual can meet the physical and environmental problems with which he is faced. The individual's degree of maturity, his previous life experiences and the nature and intensity of the other problems with which he is currently coping sculpture the emotional meaning which the problems related to having carcinoma will have for him. The degree of frustration experienced by a patient with a chronic illness governs what that individual will be able to do about securing the needed medical and physical care and making the indicated environmental adjustments, and how and when he can secure and make them.

Because of the nature of the carcinomas, a large percentage of the patients are faced with a disruption of their usual routine. The degree and duration of the disruption is dependent upon the site and the stage of advancement of the malignant growth and upon the patient's emotional status. With the usual outlets blocked, there is obviously a need for the patient to

redirect his energies. The individual patient's feelings and anxieties affect the ways in which he will be able to redirect his energies.

Of the many diseases to which human beings are subject, carcinoma is, perhaps, the most threatening to personal security. Like patients with other chronic diseases, carcinoma patients may have anxieties about subsistence for themselves and their dependents, about possible loss of prestige because of their physical disability, and about their dependency. But in addition to these sources of anxiety, the patient with a malignancy faces other threatening possibilities. The radical procedures involved in adequate treatment of cancer frequently mean that the patient will be left with a disfigurement or handicap.

In working with patients with cancer, fear seems to be a predominant obstacle that challenges dilution. The fears of the patient with carcinoma are sometimes rooted in reality factors of disability, disfigurement, pain, or death, and sometimes the fears are partially rooted in ignorance of the nature and treatability of the disease. Whichever is the case, an understanding and sympathetic caseworker by educational processes, both intellectual and emotional, may be able to help the patient work through some of his fears.

As each individual reacts to every crisis in his individual way, depending upon the nature of his individual strengths and weaknesses, it would be expected that there would be a

great variability in the reaction of patients to having carcinoma. Whether or not the patient is told of his diagnosis, the patient cannot be protected from certain realities of his illness such as the presence of symptoms and increasing disability and pain, and the need for long-term treatment and radical operations. Recent social casework articles, in which consideration is given to cancer patients, agree that there is no universal answer regarding the patient's knowing his diagnosis--that each patient possesses within himself the ability or inability to endure the truth.

The emotional significance of hospitalization, particularly for a prolonged period, is quite variable. Entering a hospital and/or remaining in one for an extended period may be an anxiety-producing experience for one patient whereas leaving a hospital may be an anxiety-producing experience for another patient.

Hospitalization may mean separation from many gratifications or it may represent receiving gratification of previously unmet needs for being cared for. Some patients can accept the dependency role with little conflict. For other patients, being in a dependency situation is guilt producing.

A multitude of emotions are precipitated by any medical treatment or procedure. That patients' reactions to advised treatment and their adjustments vary widely is expected in view of the individual differences in personality structure and life situation. These individual factors also determine the

kind of adjustment to life the patient will be able to make after an operative or treatment procedure. Dr. Michaels [2] lists as some of the determining factors in a patient's adjustment following operation as: (1) the purpose and type of the operation, (2) the structure and organization of the personality, (3) the psychosexual development, (4) the age of the patient when the operation is performed, and (5) the organ involved in the operation. The factors also seem applicable to the reaction to the other two usual methods of treatment of a cancerous growth, X-rays and radium, as well as to surgery. Another factor that may influence a patient's reaction to the recommended procedure is his own or his relatives' or acquaintances' previous experiences with a similar or what may seem to be a similar treatment process and the patient's knowledge and understanding of the procedure. Advised treatment for carcinoma may suggest to the patient his actual diagnosis from which he may have been previously successfully protected and thus unleash a torrent of distressing mental perplexities.

In the treatment of cancer, the purpose of the advised procedure is always the grim realistic one of saving the individual from a progressive and fatal illness. If the patient does not readily give consent for the advised procedure, the physician usually strongly advises it and informs the patient of the expediency of it. The patient's consent for the pro-

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2 Joseph J. Michaels, "Psychiatric Implications of Surgery", The Family, 23:363, Februay, 1943.

kind of adjustment to life the patient will be able to make after an operative or treatment procedure. Dr. Wolberg[2] lists as some of the determining factors in a patient's adjustment following operation as: (1) the purpose and type of the operation, (2) the structure and organization of the personality, (3) the psychosexual development, (4) the age of the patient when the operation is performed, and (5) the organ involved in the operation. The factors also seem applicable to the reaction to the other two usual methods of treatment of a cancerous growth, X-rays and radium, as well as to surgery. Another factor that may influence a patient's reaction to the recommended procedure is his own or his relatives' or acquaintances' previous experiences with a similar or what may seem to be a similar treatment process and the patient's knowledge and understanding of the procedure. Advised treatment for cancerous may suggest to the patient his actual diagnosis from which he may have been previously successfully protected and thus unleash a torrent of distressing mental perplexities.

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cedure frequently represents an even greater fear for not having the advised treatment than his intensive fear of the procedure itself.

The organization and structure of each individual's personality is an active factor in determining what feelings, both unconscious and conscious, will dominate the patient's reaction to advised treatment. The patient with a compulsive neurotic personality pattern and the patient with a hysterical neurotic personality pattern may unconsciously find a secondary gain in the operative or treatment procedure. An operative or other painful procedure may represent punishment for hostile feeling or unacceptable love wish and thus bring satisfaction by diluting feelings of anxiety and guilt. Other individuals may find an unconscious pleasure in painful treatment in that it represents submitting to a seemingly strong and omnipotent person--the physician or surgeon. Attention, sympathy, pity, and evidences of love which patients under intensive treatment receive may be a secondary gain for other patients.

Those patients whose personality pattern is dominated by distrust and suspicion may look upon the operation as an abusive thing in which he (or she) is being used as a guinea pig. The degree to which the patient's emotional needs are being satisfied by his family setting and his interests outside himself directly affects the degree to which an operation or other treatment procedure many hold secondary gains for the individual and thus influences the emotional meaning of the operation

to the patient. The emotional component blends with the reality factors of the patient's physical condition in determining the patient's post-treatment state.

Dr. Michaels[3] points out that the individual's psychosexual development is the prototype for all later behavior of the individuals. The psychosexual development is of particular significance in determining the unconscious meaning that operations which are as disfiguring as many of those which are performed to arrest cancerous growth will have for the patient. It has frequently been observed that, in general, women's reactions to operations are more severe than those of men. This development has a much more complex evolution in the female than in the male. The premise that many of the fantasies of destruction and mutilation in relation to an operative procedure are associated with sexual behavior points toward the contribution of the individual's psychosexual development to his reaction to the procedure.

The time of life at which an individual undergoes an operation is of significant import. Knowledge of the shifting in balance of forces of the personality which occur during the first six years of life, puberty, and the climacterism, suggests that operations may be more traumatic emotionally during these times than at other periods. The fact that the highest incident rates of cancer, a disease for which the only suitable

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3 Michaels, ibid, p. 366.

treatment frequently is an operative procedure, fall in periods of life for male and female which bear a general correspondence to their usual respective climacterism age range is significant.

Organ significance seems to be worthy of careful consideration in exploring the emotional implications of carcinoma as those organs that are especially prone to be invested with conscious and unconscious significance, the urogenital organs, are frequently the site of the cancerous growth. Among women, the most common sites of carcinoma are the womb, the breast, the intestines and rectum, stomach, and genito-urinary organs. Lips, lungs, stomach, prostate gland, intestines and rectum, and genito-urinary organs are the most common zones for malignant growths in men. The site of the malignant growth may also be significant from the standpoint of fitting into the patient's guilt feelings in that the growth may occur in a part of the body which the patient associates with what he considers to be a misdeed as is exemplified by one of the cases presented in Chapter Five.[4]

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4 See page 82.

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4 See page 82.

CHAPTER IV

THE PATIENT GROUP

After having considered some of the social and emotional implications of chronic illness in general and carcinoma in particular, it seems appropriate, prior to proceeding to the presentation of individual cases, to examine certain characteristics and circumstances of the patient group studied. Particular consideration will be given to the reason for their referral to the Social Service Department, the problems recognized in these cases, the services given them, and the limitations affecting the meeting of recognized needs.

Age and Sex

Of the forty-eight carcinoma patients whose records were used as a basis for this study, twenty-two were men and twenty-six were women. Although this sampling is relatively small and is subject to the selectivity factors involved in the choice of hospital and in the referral to the Social Service Department, these finding regarding sex distribution are in accord with other statistics in that about the same number of men and women sometime during their life fall victim to cancer. In 1944 for example, the National Office of Vital Statistics

reported cancer as the cause of death of 89,005 women and 82, 166 men.[1]

The ages of the patients in this study range from twenty-eight to eighty-nine. The age range for the males is from fifty-two to eighty-nine whereas for the females it is from twenty-eight to seventy-seven. The study of sex distribution according to age is recorded in Table IV and shows a difference between sexes which is in general agreement with other studies

TABLE IV

AGE AND SEX DISTRIBUTION OF PATIENT GROUP

Age Group	Males	Females	Total
25 - 34	--	2	2
35- 44	--	2	2
45 - 54	1	5	6
55 - 64	4	8	12
65 - 74	13	7	20
75 - 84	3	2	5
85 - 94	1	--	1
Total	22	26	48

regarding this relationship in that carcinoma has been observed to be more prevalent among women than men in the under-sixty age group and more frequent in occurrence in males than in females in the over-sixty age group. However, because of the relatively small number of cases and the above mentioned

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1 The American Cancer Society, Facing the Facts About Cancer, p. 5.

elements of selectivity involved in this study, these statistics fail to show the accepted fact that cancer can occur at any age in either sex.

As with any other chronic disease, the age at which a person becomes in some degree incapacitated by carcinoma is an important determinant in what meaning the illness is going to have, both socially and emotionally, to the individual patient.

Color, Religion, and Cultural Background

The color and the religion of the individual patient affects the community resources available for the patient. (Citizenship and state residence affect elgibility for public assistance and status of settlement influences the time required to establish elgibility for public assistance, but data regarding these factors were not available for a sufficient number of the cases studied to be of value.) The color, religion and cultural background all, of course, have been influencing factors upon each patient's personality structure and the latter may directly affect the patient's ability to cope with the problems of chronic illness unaided.

Five of the forty-eight patients whose records were studied were Negro and the remaining forty-three were white. In making plans for convalescent home and nursing home care, the color of the patient is an important factor in regard to the

availability of the resident care facilities. For example, nursing and convalescent home facilities for Negro patients are rather limited.

Religion, like color, is an important factor in the selection and availability of resources for the individual patient. Jewish patients in need of hospital care may be accepted at Jewish Memorial Hospital. Catholic Charities and Jewish Family Services are possible resources for funds with which some of the needs of patients of those respective faiths can be met. Religious faith is also a factor in finding a place of resident care in which the patient can make the best adjustment. Catholic patients generally prefer Catholic institutions. Although many Catholic hospitals and homes will accept Protestant patients, the surroundings of a Catholic institution(such as the statues and the robed sisters which are a source of comfort for the Catholic patient) contribute to the anxiety of some Protestant patients. The cost of board at most Jewish nursing homes frequently is a precluding factor in placing the Hebrew patient in a home where he will be served kosher food. Of the patients in this study group, forty-four per cent were Catholic, forty per cent were Protestant, and ten per cent were Hebrew. The religious affiliation of six per cent of the patients is unknown.

Twenty-eight, or slightly more than fifty-eight per cent, of the forty-eight patients were of foreign birth. The records of almost all of these patients show that they came to the

availability of the resident care facilities. For example, nursing and convalescent home facilities for Negro patients are rather limited.

Religion, like color, is an important factor in the selection and availability of resources for the individual patient. Jewish patients in need of hospital care may be accepted at Jewish Memorial Hospital. Catholic Charities and Jewish Family Services are possible resources for funds with which some of the needs of patients of those respective faiths can be met. Religious faith is also a factor in finding a place of resident care in which the patient can make the best adjustment. Catholic patients generally prefer Catholic institutions. Although many Catholic hospitals and homes will accept Protestant patients, the surroundings of a Catholic institution(such as the statues and the robed sisters who are a source of comfort for the Catholic patient) contribute to the anxiety of some Protestant patients. The cost of board at most Jewish nursing homes frequently is a precluding factor in placing the Hebrew patient in a home where he will be served kosher food. Of the patients in this study group, forty-four per cent were Catholic, forty per cent were Protestant, and ten per cent were Hebrew. The religious affiliation of six per cent of the patients is unknown.

Twenty-eight, or slightly more than fifty-eight per cent, of the forty-eight patients were of foreign birth. The records of almost all of these patients show that they came to the

United States as young adults. Some of these patients and members of their families had language difficulties which, because of their inability to understand or make themselves understood, seemed to intensify their fears. A number of these patients who were born and reared in another country needed considerable interpretation regarding the resources and help in availing themselves of the use of these resources.

Marital Status and Mode of Living

The patient's marital status and his mode of living prior to hospital admission have a profound effect upon his discharge plans. Patients who have been living alone or in a rooming house and have no relatives with whom they can stay for a period frequently need to go to a convalescent home or nursing home to receive a special diet or simple medication and care. In other cases, the patient or a member of his family, most frequently the spouse, is emotionally unable to accept recommendations for nursing home or institutional plans even though the patient is in need of much care and/or palliative treatment.

When the patient has been living with his or her spouse and/or other members of the family, plans sometimes need to be made for assumption of the financial and other responsibilities formerly assumed by the patient.

The marital status of the patients in relation to their

age and their mode of living prior to hospitalization as related to sex are presented in Tables V and VI. These statis-

TABLE V

AGE & SEX OF PATIENTS IN RELATION TO MARITAL STATUS

Age Group	Marital Status								Total
	Single		Married		Widowed		Divorced or Separated		
	M	F	M	F	M	F	M	F	
25-34	0	1	0	1	0	0	0	0	2
35-44	0	0	0	2	0	0	0	0	2
45-54	0	1	1	2	0	1	0	1	6
55-64	0	2	4	3	0	2	0	1	12
65-74	0	1	8	2	4	3	1	1	20
75-84	0	0	2	0	1	2	0	0	5
85-94	0	0	1	0	0	0	0	0	1
Total	0	5	16	10	5	8	1	3	48

tical devices, however fall far short of presenting the total picture. The figures on the tables do not reveal the capacity of a member of members of the patient's household to care for the patient or how many and in what way members of the household have been dependent upon the patient. Three of the male patients and three female patients (one widowed) are known to have had one or more children under eighteen years of age. One of the woman patients had five children who ages ranged from two years to twelve. Other patients had incapacitated dependents. For example, one man's blind wife was alone when

Age Group	Marital Status								Total
	Single		Married		Widowed		Divorced or Separated		
	M	F	M	F	M	F	M	F	
25-34	0	1	0	1	0	0	0	0	2
35-44	0	0	0	2	0	0	0	0	2
45-54	0	1	1	3	3	1	0	1	8
55-64	0	2	4	3	0	2	0	1	12
65-74	0	1	8	2	4	3	1	1	20
75-84	0	0	2	0	1	2	0	0	5
85-94	0	0	1	0	0	0	0	0	1
Total	0	5	16	10	8	8	1	3	48

TABLE VI

MODE OF LIVING

Mode of Living	Male	Female	Total
Alone	--	8	8
Spouse	5	6	11
Spouse & Children	9	3	12
Children Without Spouse	4	4	8
Other Relatives	1	3	4
Rooming House	3	1	4
Place of Employment	--	1	1
Total	22	26	48

the patient was hospitalized.

Source of Income

The lack of finances is a complicating factor the social worker frequently encounters in helping patients and their families in arranging for the patients' care in accordance with the doctors' recommendations. As can be seen in Table VII, (on the following page) at the time of their first 1947 hospitalization, sixty-nine per cent of the patients included in this study were self-supporting, fourteen and one-half per cent were dependent on relatives, and sixteen and one-half per

TABLE VI

MODE OF LIVING

Mode of Living	Male	Female	Total
Alone	--	8	8
Spouse	6	5	11
Spouse & Children	9	3	12
Children without Spouse	4	4	8
Other Relatives	1	3	4
Rooming House	3	1	4
Place of Employment	--	1	1
Total	23	25	48

the patient was hospitalized.

Source of Income

The lack of finances is a complicating factor the social worker frequently encounters in helping patients and their families in arranging for the patients' care in accordance with the doctors' recommendations. As can be seen in Table VII, (on the following page) at the time of their first 1947 hospitalization, sixty-nine per cent of the patients included in this study were self-supporting, fourteen and one-half per cent were dependent on relatives, and sixteen and one-half per

cent were receiving public assistance. Carcinoma is an incapacitating disease and a disease for which treatment and care are expensive. There were only fourteen and one-half per cent

TABLE VII

SOURCE OF INCOME OF PATIENTS AT TIME OF FIRST 1947 HOSPITAL ADMISSION

Source of Income	No. of Patients
Self Supporting	33
Dependent on Relatives in Home	4
Dependent on Relatives Out of Home	2
Dependent on Relatives In & Out Of Home	1
Public Welfare	1
Old Age Assistance	7
Total	48

of the cases in which finances was not known to present problems or at least limitations. In seven of the fourteen cases which make up this fourteen and one-half per cent, the recorded material gave no indication of financial status. Since arrangements for payment of Peter Bent Brigham Hospital bills are handled exclusively by the hospital's admitting office, problems related to payment of such bills were not reflected in the medical or Social Service records on which the above statistics are based.

Prognosis, Period of Hospitalization, and Operations

The physical status of a patient while in the hospital and the prognosis regarding the future course of the disease with which he is afflicted are determining and limiting factors in the role of the medical caseworker in working with that individual. In the recordings regarding fourteen of the forty-eight patients studied there were indications that the patient was too ill to participate in planning for his own care. A poor prognosis, particularly regarding carcinoma, has such an intense emotional meaning to the members of the patient's immediate family, that they frequently need considerable help in working through their feelings to the point where they can participate in making adequate plans for the care of the patient.

The prognoses at the time of discharge from the last 1947 hospitalization, of forty-four of the forty-eight patients on whose cases this study is based are presented in relationship to age in Table VIII on page 44. (Four of the patients died during a 1947 hospitalization. The ages of these patients were sixty-six, thirty-three, seventy-five, and seventy-eight. Prognoses of the patients are classified as good, questionable, and poor based on the doctors' statements contained in the medical records. All of the five patients for whom the prognosis was considered to be good had undergone radical surgical procedure of such a nature as to impose certain limitations even after the convalescent period. The eleven patients with

Prognosis, Period of Hospitalization, and Operations

TABLE VIII

PROGNOSES OF PATIENTS ACCORDING TO AGE

Age Group	Prognosis			Total
	Good	Questionable	Poor	
25 - 34			1	1
35 - 44			2	2
45 - 54	3	1	2	6
55 - 64	1	5	6	12
65 - 74	1	4	14	19
75 - 84			3	3
85 - 94		1		1
Total	5	11	28	44

prognoses designated as questionable were those under active treatment, the results of which could not yet be predicted, and those who were being followed closely following recent treatment. For twenty-eight or about sixty-five per cent of the patients living at time of discharge the prognosis was poor. For thirteen of the twenty-eight with a poor prognosis immediate plans for terminal care were indicated.

Although the patient's total personality and his current life situation as well as many other factors in his illness, are active agents in determining what hospitalization means to the individual patient, the length of the period of hospitalization seems worthy of some consideration. Whatever the social

TABLE VIII

PROGNOSES OF PATIENTS ACCORDING TO AGE

Age Group	Prognosis			Total
	Good	Questionable	Poor	
25 - 34			1	1
35 - 44			2	2
45 - 54	3	1	2	6
55 - 64	1	5	6	12
65 - 74	1	4	14	19
75 - 84			3	3
85 - 94		1		1
Total	5	11	28	44

and emotional meanings of the hospitalization to t he individual patient, these meanings are influenced by the length of time the patient is removed from his natural environment.

In Table IX, the number of days in 1947 the forty-eight patients whose cases were examined for this study, were hospitalized during this period is shown in relationship to the

TABLE IX

NUMBER OF HOSPITALIZED DAYS DURING 1947 IN RELATION TO PLACE TO WHICH PATIENT WAS DISCHARGED FROM LAST 1947 HOSPITALIZATION

Number of Days Hospitalized	Total No. of Patients	Destination of Patients at Discharge						
		Own Home	Conv. or Nurs. Home	Term. Care Hosp.	T. B. Sanitarium	Treatment Hosp.	Not Specified	Death
Under 10	5	2	1	2	--	--	--	--
10 - 19	9	5	--	3	--	1	--	--
20 - 29	10	3	5	--	--	--	1	1
30 - 39	9	3	3	2	1	--	--	--
40 - 49	4	4	--	--	--	--	--	--
50 - 59	6	4	1	--	--	--	--	1
60 - 69	0	--	--	--	--	--	--	--
70 - 79	0	--	--	--	--	--	--	--
80 - 89	1	--	--	--	--	--	--	1
90 - 99	0	--	--	--	--	--	--	--
Over 100	4	1	1	1	--	--	--	1
Total	48	22	11	8	1	1	1	4

places to which the patients were discharged at the close of their last 1947 hospitalization. These figures in Table IX do not accurately reflect either the total need of these carcinoma patients for special nursing and medical care or the total period of these patients' separation from their usual environment. These figures show only the periods these patients were hospitalized during one year in an active treatment hospital. It is interesting to note that only fifty per cent of the patients living at discharge were discharged to their usual place of abode. The remaining fifty per cent of the patients entered convalescent and nursing homes or other hospitals where they continued to be separated from their family, friends, and usual environment. It is not known how many of the patients who went home from the hospital entered nursing homes or other hospital at a later date. The social service recordings for eight of the patients who were discharged to their own homes do reveal that financial or emotional factors prevented these patients and/or members of their families from accepting their doctors' recommendations of nursing home or institutional care.

"A whole new set of emotional factors are set loose as the result of surgical procedure".[2] Of the forty-eight carcinoma patients whose case histories are the basis of this study, all but one underwent at least one surgical operation either for diagnostic or treatment purposes. Tables X and XI show the number of exploratory and therapeutic operations

2 Helen Leland Witmer, Teaching Psychotherapeutic Medicine, p. 32.

TABLE X

NUMBER OF EXPLORATORY OPERATIONS PER PATIENT
DURING 1947 HOSPITALIZATIONS

No. of Exploratory Operations	No. of Patients
None	30
One	9
Two	7
Three	2
Total	48

TABLE XI

NUMBER OF THERAPEUTIC OPERATIONS PER PATIENT
DURING 1947 HOSPITALIZATIONS

No. of Therapeutic Operations	No. of Patients
None	19
One	25
Two	2
Three	2
Total	48

performed on the forty-eight patients. No therapeutic operation was performed on seven of the eighteen patients who underwent examination by biopsy. Of these seven patients, two had had

TABLE X

NUMBER OF EXPLORATORY OPERATIONS PER PATIENT
DURING 1946 HOSPITALIZATIONS

No. of Exploratory Operations	No. of Patients
None	30
One	9
Two	7
Three	2
Total	48

TABLE XI

NUMBER OF THERAPEUTIC OPERATIONS PER PATIENT
DURING 1946 HOSPITALIZATIONS

No. of Therapeutic Operations	No. of Patients
None	19
One	25
Two	2
Three	2
Total	48

performed on the forty-eight patients. No therapeutic operation was performed on seven of the eighteen patients who underwent examination by biopsy. Of these seven patients, two had had

therapeutic operations prior to 1947. Seven of the the patients who underwnt therapeutic operations in 1947 previously had undergone at least one operation directed toward removing a malignant growth.

The very fact that all but one of the forty-eight patients included in this study underwent at least one operation indicates the emotional factors related to surgery are factors frequently present in the emotional component of the total situation of the patient who is under active treatment for carcinoma.

As pointed out in Chapter Three[3], among certain organs which are especially prone to be invested with conscious and unconscious significance, are the urogenital organs. In Table XII, the location of the primary site of carcinoma tissue in the forty-eight patients whose cases were studied is shown. The location of the primary site of the malignant growth was in a breast, an ovary, or the cervix in fifteen of the twenty-six women. In seven of the twenty-two men the primary site of the cancer was in the bladder or prostate. With the exception of the primary site of epidermoid carcinoma of the cheek which occurred in one woman, all other primary sites, in both the males and females other than those mentioned above, were located in the gastro-intestinal tract. In twenty-six, or fifty-four per cent, of the patients the carcinoma had metasticized.

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3 Chapter III, p. 34.

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[3] Chapter III, p. 34.

TABLE XII

PRIMARY SITE OF CARCINOMA TISSUE

Primary Site	Male	Female	Total
Bladder	3	--	3
Ovary	--	4	4
Sigmoid	2	--	2
Breast	--	7	7
Colon	2	2	4
Esophagus	1	--	1
Stomach	5	3	8
Prostate	4	--	4
Rectum	4	3	7
Pancreas	--	1	1
Cervix	--	4	4
Liver	1	1	2
Epidermoid c.a. of cheek	--	1	1
Total	22	26	48

Sources of Referral of Patients to the Social Service Department

The Social Service Department at the Peter Bent Brigham Hospital does not automatically review the situation of all patients in the diagnostic category of carcinoma, but considers the needs and problems of those patients referred to the department. The sources of the referral to the Social Service Department of the forty-eight cases used as the basis for this study are presented in Table XIII. These forty-eight cases are that portion of the total of sixty-two cancer patients hospitalized sometime during 1947 who were referred to the

TABLE XII

PRIMARY SITE OF CANCEROUS TISSUE

Primary Site	Male	Female	Total
Bladder	3	--	3
Ovary	--	4	4
Sigmoid	2	--	2
Breast	--	7	7
Colon	2	2	4
Esophagus	1	--	1
Stomach	3	3	6
Prostate	4	--	4
Rectum	4	3	7
Pancreas	--	1	1
Cervix	--	4	4
Liver	1	1	2
Gallbladder & duct	--	1	1
Total	22	26	48

Sources of Referral of Patients to the Social Service Department

The Social Service Department at the Peter Bent Brigham Hospital does not automatically review the situation of all patients in the diagnostic category of cancerous, but considers the needs and problems of those patients referred to the department. The sources of the referral to the Social Service Department of the forty-eight cases used as the basis for this study are presented in Table XIII. These forty-eight cases are that portion of the total of sixty-two cancer patients hospitalized sometime during 1947 who were referred to the

Social Service Department regarding whom sufficient information for the purposes of this study was available. The sixty-two cases referred to Social Service represent 19.8 per cent of the three hundred and thirteen patients with a diagnosis of carcinoma who were in the Peter Bent Brigham Hospital during the year of 1947.

TABLE XIII

SOURCES OF REFERRAL OF PATIENTS TO SOCIAL SERVICE

Source of Referral	No. of Patients
Physician	40
Nurse	3
Relatives	1
Patient	2
Outside Social or Public Health Agency	1
Not Specified	1
Total	48

It is interesting to note that forty of the forty-eight initial referrals were made by physicians. Whether or not the three referrals listed as being made by a nurse were made at the suggestion of a physician cannot be determined from the information recorded. Both of the two patients who made their own initial contacts with the Social Service Department were

later referred by physicians for other services. The one case referred to the Social Service Department by an outside agency was later called to the attention of a medical social worker by a nurse on the ward in which the patient was hospitalized. In only two cases of the forty-eight, the one referred by a relative of the patient and the one in which there was no information regarding the sources of the referral, were there no indications of either a doctor or a nurse recognizing some need regarding which the services of a medical caseworker was sought.

Needs For Which the Patients Were Referred To Social Service Department

The needs of the patients, recognized in all but two of the forty-eight cases by a doctor or nurse regarding which the referrals were made to the Social Service Department are presented in relation to the patients' prognoses in Table XIV.

Slightly more than thirty-one per cent of the patients were referred for social study. In seven of the fifteen cases in which the doctors requested a social study of the patient's circumstances, the request was made for the purpose of evaluating the patient's home in regard to its appropriateness as a place to which to discharge the patient. The prognoses for four of these six patients was poor and the physicians in charge of these patients during their period of hospitalization

considered an appraisal of the emotional and physical ability of members of the patients' families to give the patients terminal care important to formulating discharge recommendations.

TABLE XIV

REASON FOR REFERRAL OF PATIENTS AS RELATED TO PROGNOSIS

Reason For Referral	Prognosis			Total
	Good	Questionable	Poor	
Social Study	4	4	7	15
Terminal Care Plans	-	-	7	7
Nursing Home Plans	-	3	6	9
Referral to V.N.A.	-	1	5	6
Family Planning	-	-	3	3
Transportation to clinic follow-up care)	-	1	2	3
Convalescent Home Care	-	1	1	2
Blood Donor	-	-	1	1
Employment	1	-	-	1
Financial Planning	1	-	-	1
Total	6	10	32	48

In two cases a doctor requested a Social Service study for the purpose of gaining more information regarding the Patient's background and home situation for the purpose of better understanding the emotional component which seemingly was delaying these patients' physical progress. Although one of these patients' prognoses was poor at the time of the last 1947 discharge, the prognosis of each was considered to be good at the time of referral. Social studies were requested in five cases for the purpose of gaining a better understanding of why these

patients were hesitant to accept recommendations for specific hospital or clinic treatment. Of this group of five patients, three were considered to have a questionable prognosis, one had a good prognosis and one a poor prognosis. In another case, the doctor's referral of a patient for social study was based on recognition of the patient's anxiety regarding plans for her future following a mutilating operation. The prognosis for this patient was considered to be good. In each of these fifteen cases which were referred by a doctor for social study, the referring physician was seeking social recommendation to help him in formulating medical care recommendations that would be as appropriate as possible to the patient's social and emotional status.

The other thirty-three referrals were made in regard to specific needs. In thirty-two of these cases the referring person was requesting the caseworker to assist the patient and/or his family in making certain arrangements related to facilitating the patient's following medical recommendations. One patient was referred for assistance in finding employment following her physical recuperation from an operation in which a colostomy was done. Of these thirty-three patients referred for a specific service, over seventy-five per cent were considered to have a poor prognosis, eighteen per cent--a questionable prognosis, and six per cent--a good prognosis.

patients were judged to accept recommendations for specific hospital or clinic treatment. Of this group of five patients, three were considered to have a questionable prognosis, one had a good prognosis and one a poor prognosis. In another case, the doctor's referral of a patient for social study was based on recognition of the patient's anxiety regarding plans for her future following a mutilating operation. The prognosis for this patient was considered to be good. In each of these fifteen cases which were referred by a doctor for social study, the referring physician was seeking social recommendation to help him in formulating medical care recommendations that would be as appropriate as possible to the patient's social and emotional status.

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Recognized Medical-Social Problems Of The Patients

In Chapter Three[4], the social and emotional implications of carcinoma were considered, and, for the purpose of convenience in discussion in that chapter, the problems of patients were divided into three general groups: (1) problems related to the need for physical care, (2) problems related to the need for environmental adjustments, and (3) emotional problems precipitated, reactivated, or intensified by the illness. As stated in that chapter, these three groups of problems are not clear cut, but, instead are interwoven one with the other, each affecting the others within the framework of the total individual personality. This classification of problems is not being followed in the present chapter, but instead the recognized problems of the patients in the study group are enumerated as: (1) those related to arrangements for physical care, (2) those related to finances, (3) those of an emotional nature, and (4) those of members of the patient's family as related to the patient's illness. This latter classification was chosen as it lends itself more readily to a parallel classification of services offered to the patients and members of their families by medical caseworkers toward meeting the recognized needs.

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4 Page 20.

Recognized Medical-Social Problems of the Patients

The Social Service recording on each of the forty-eight patients whose cases were studied were carefully reviewed by use of Section V of the schedule [5], and all needs of the patients were classified as presented in Table XV. In many instances there was a relationship between several separately enumerated needs with one listed need being the precipitating factor for one or more other listed needs.

Cancer was, of course, a problem common to all the patients and all needed to have certain arrangements for physical care. The needs enumerated in Table XV as related to arrangements for physical care are those needs for the various specific types of care for which patients and/or members of their families were unable to make without some assistance. (These figures represent the problems, and, as would be expected, some of the patients and/or members of their families, because of various limitations, were unable to plan for the indicated care with the assistance of the medical social worker.) In three of the forty-eight cases, the recorded material gave no evidence that the patient and/or his family had experienced any need for assistance in arranging for the recommended physical care of the patient, that is, in arranging for recommended treatment, convalescent home, nursing home, terminal or home care. In forty-five cases there are indications of a total of fifty-two needs for arrangements being made for the

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5 See Appendix, p. 102

The Social Service preceding on each of the forty-eight patients whose cases were studied were carefully reviewed by use of Section V of the schedule [5], and all needs of the patients were classified as presented in Table XV. In many instances there was a relationship between several separately enumerated needs with one-listed need being the precipitating factor for one or more other listed needs.

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5 See Appendix, p. 109

TABLE XV

RECOGNIZED MEDICAL-SOCIAL PROBLEMS

Problem			Number
1. Related to Arrangements for Physical Care - - - - - - - -			52
a. Need for planning for further treatment		4	
b. Need for planning for convalescent care		2	
c. Need " " " nursing home care		13	
d. " " " " terminal care		13	
e. " " " " home care		19	
f. " " securing blood donors		1	
2. Related To Finances - - - - - - - - - - - - - - - - - - -			47
a. Need related to cost of medical care, medication, diets, and appliances		7	
b. Need related to both medical care and living expenses		7	
c. Need related to planning for convalescent, nursing home, and terminal care or housekeeping services		20	
d. Need related to transportation to clinic or place of resident care		13	
3. Problems of an Emotional Nature - - - - - - - - - - - - -			29
a. Precipitated by Illness		20	
(1) Precipitated by the illness itself	15		
(2) Precipitated by operative procedures	5		
b. Existent prior to illness and affecting planning for treatment and care		9	
4. Problems of Members of Patient's Family As Related to Patient 's Illness - - - - - - - - - - - - - - -			27
a. Emotional Problems related to members of patient's family accepting patient's illness and recommendations for care		21	
b. Need for help in planning for care for members of patient's family		3	
c. Problems presented because of disinterest of members of patient's family		3	
Grand Total Of All Recognized Problems			155

TABLE XV

RECOGNIZED MEDICAL-SOCIAL PROBLEMS

Problem	Number
1. Related to arrangements for physical care - - - - - - - -	82
a. Need for planning for further treatment	4
b. Need for planning for convalescent care	3
c. Need " " " nursing home care	13
d. " " " " terminal care	13
e. " " " " home care	19
f. " " securing blood donors	1
2. Related to Finances - - - - - - - - - - - - - - - - - - -	47
a. Need related to cost of medical care, medication, diets, and appliances	7
b. Need related to both medical care and living expenses	7
c. Need related to planning for convalescent, nursing home, and terminal care or housekeeping services	20
d. Need related to transportation to clinic or place of resident care	13
3. Problems of an Emotional Nature - - - - - - - - - - - - -	59
a. Precipitated by Illness	20
(1) Precipitated by the illness itself	15
(2) Precipitated by operative procedures	5
b. Existent prior to illness and affecting planning for treatment and care	9
4. Problems of Members of Patient's Family As Related to Patient's Illness - - - - - - - - - - - -	27
a. Emotional problems related to members of patient's family accepting patient's illness and recommendations for care	21
b. Need for help in planning for care for members of patient's family	3
c. Problems presented because of disinterest of members of patient's family	3
Grand Total Of All Recognized Problems	185

patients' physical care. Of these needs for planning, fifty-four per cent were for convalescent, nursing home, or terminal care, thirty-seven per cent were for home care, and eight per cent for further treatment. The need for planning for home care of the patient embraces the need for services of the Visiting Nurses Association, the need for arranging for nursing care in the home, and the need for interpreting to the patient and/or members of his family, diets and procedures of care. The needs related to planning for further treatment, which were shown by the recordings regarding four patients, were for these patients to have help in accepting and making plans whereby they could arrange to have specific treatment.

The recorded material regarding thirty-nine of the patients revealed a total of forty-seven financial problems affecting planning for the patient's care. Financial problems were recorded under more than one category for one patient only when the problems occurred at separate times in the period during which the patient was known to the Social Service Department. Slightly more than forty-two per cent of the problems affected planning for resident care for the patient at a convalescent home, nursing home, or terminal care hospital. About twenty-eight per cent of the financil problems were related to obtaining for the patient an appropriate means of transportation to clinic for medical follow-up or to a place of resident care. About fifteen per cent of the problems were related to the cost of medical care, medication, diets, and appliances exclusive

patients' physical care. Of these needs for planning, fifty-four per cent were for convalescent, nursing home, or terminal care, thirty-seven per cent were for home care, and eight per cent for further treatment. The need for planning for home care of the patient embraces the need for services of the Visiting Nurses Association, the need for arranging for nursing care in the home, and the need for interpreting to the patient and/or members of his family, diets and procedures of care. The needs related to planning for further treatment, which were shown by the records regarding four patients, were for these patients to have help in accepting and making plans whereby they could arrange to have specific treatment.

The recorded material regarding thirty-nine of the patients revealed a total of forty-seven financial problems affecting planning for the patient's care. Financial problems were recorded under more than one category for one patient only when the problems occurred at separate times in the period during which the patient was known to the Social Service Department. Slightly more than forty-two per cent of the problems affected planning for resident care for the patient at a convalescent home, nursing home, or terminal care hospital. About twenty-eight per cent of the financial problems were related to obtaining for the patient an appropriate means of transportation to clinic for medical follow-up or to a place of resident care. About fifteen per cent of the problems were related to the cost of medical care, medication, diets, and appliances exclusive

of the cost of hospitalization and clinic visits at the Peter Bent Brigham Hospital except in two cases. Information was not available regarding how many of the patient group presented their problems concerning payment of hospital bills and clinic fees directly to the admitting office. Fifteen per cent of the financial problems represents those of six patients regarding their limitations in meeting both their living expenses and medical expenses.

Analysis of the emotional problems of the patients in the study group from the summarized social service recordings or medical consultation sheets was a difficult process and one subject to inherent limitations. The recordings indicated that twenty-nine patients presented symptoms of emotional problems which affected planning for their medical treatment and/or plans for their care. Of the remaining nineteen patients, fourteen were too ill to be seen, four were seen in too limited a capacity for emotional symptoms to be considered, and one patient was evaluated as presenting no emotional problems.

Because of the brevity of the available records, the classification of the emotional problems is necessarily somewhat arbitrary and the discussion is based upon the symptoms rather than upon the diagnoses of the emotional problems. In twenty of the patients the emotional symptoms seems to have been precipitated by the illness itself or by an operation performed in treatment of the malignant growth, although, of course, it is recognized that these patients' reactions to their illness

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and operation were based on their total personality structures. The emotional symptoms presented by nine patients were those of discouragement and acute anxiety about the future. It was interesting to note that all of these nine patients either had as dependents, minor children or incapacitated members of their family, or were totally without any close relatives. Two of the patients minimized their symptoms and were unrealistically optimistic. Four patients were extremely fearful regarding acceptance of nursing home plans which would separate them from their families. Of these four patients, two expressed feelings of guilt and gave indications of attributing their illness to their past behavior. Five patients, each of whom had a colostomy, experienced considerable difficulty in accepting their physical condition and were quite fearful about leaving their place of abode and being with people.

Nine patients presented certain emotional symptoms which seemed to have a closer relationship to their previous emotional adjustment than those described above. Of these nine, three, all of whom had a history of being in friction with members of their families, seemed to use their illness for secondary gains and were over-demanding. Three patients who had a long history of rigid independence were resistant to recommendations for care which required their being dependent. For two patients, their long-existing overprotective attitude toward their children presented problems in planning for their medical care in that these patients could not feel free to remain in the

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hospital as recommended. One patient had a history of extreme withdrawal for a period of five years prior to her being diagnosed as having carcinoma. Her emotional status affected her ability to carry out treatment plans.

A review of the recorded material regarding the forty-eight patients in the study group revealed that in twenty-five cases problems in the family situation affected either the formulation or execution of plans for the patients' care. In two of these twenty-five cases there were two problem areas. Neither the presence or absence of problems of members of the patient's family was specified in the available material regarding ten patients. The social service records indicated that the relatives of eight patients showed a capacity for accepting these patients' illnesses and for participating in planning for the patients' care in a realistic manner. Five patients had no relatives.

Of the twenty-seven problems noted in the patients' family situations, twenty-one were related to one or more of the members of the patient's family having difficulty in emotionally accepting the patient's illness and recommendations for the patient's care. Six husbands and seven wives of patients experienced difficulty in accepting the reality of their respective spouse's critical condition and poor prognosis, and their feelings of inadequacy and bewilderment dominated the situation, at least, until with the help of a caseworker they were able to work through some of their feelings. Most of these patients'

spouses as well as five patients' daughters had considerable feeling about the nursing home and terminal hospital placements recommended for the patients, and some of these relatives were unable to accept the recommendations and attempted to care for the patient at home. Some of the relatives who recognized the necessity or advisability of resident care for the related patient were beseiged by guilt feelings regarding their not being able to care for the patient at home. The wife of one of the patients, in addition to being unable to accept recommendations for nursing home plans, showed an incapacity for accepting her husband's incontinency and poorly-regulated colostomy, and her lack of acceptance of these conditions contributed to the patient's intense feeling about them. The husband of one of the patients, not included in those previously mentioned, seemed to be unable to express guilt feelings, but acted them out by demanding special services for his wife, such as special nurses' services, when such services were not indicated. This husband's concern about special services not needed and not available added to the patient's anxiety. The disintegrating of family unity among the seven children of one patient contributed to this patient's difficulty in making adequate plans for care. One adult son's emotionally immature behavior, including his threatening his mother with discontinuance of his financial support if she re-entered the hospital, was a barrier to this patient's following the best possible medical plan.

The making and execution of plans for housekeeping services

was essential to three patients being able to accept remaining in the hospital for treatment or entering a terminal care hospital. In two of these cases the patient was a mother of several small children and in the third case the patient was the husband of a blind wife.

Planning for the care of three other patients was complicated by the disinterest of members of the patients' families. In all three of these cases members of the patient's family had little positive feeling for the patient because of the patient's past behavior and these relatives were not able to participate in planning in a way constructive to the patient's emotional well-being.

The recognized medical-social problems in all areas total one hundred fifty-five for the forty-eight patients. In Table XVI the number of problems encountered in patient situations is

TABLE XVI

NUMBER OF PROBLEMS PER PATIENT
(IN ADDITION TO THE PROBLEM OF ILLNESS)

Number of Problems	No. of Patients	Total Problems
One	8	8
Two	8	16
Three	11	33
Four	12	48
Five	5	25
Six	3	18
Seven	1	7
Total	48	155

presented. The recorded material regarding the patients gave indication of the existence of one medical-social problem in seventeen per cent of the group, of two problems in seventeen per cent, of three problems in twenty-three per cent, of four problems in twenty-five per cent, of five problems in ten per cent, of six problems in six per cent, and of seven problems in two per cent. Both the arithmetic average and the median of the number of recognized medical-social problems in each of the forty-eight patient situations studied is three.

Services Offered to the Patients and Members Of the Patients' Families by Social Service

The Social Service Department of the Peter Bent Brigham Hospital on whose recording this study is based, does not, as previously stated, interview all patients with a diagnosis of carcinoma and/or members of the patients' families. Carcinoma patients become known to a social worker at such time as a doctor, a nurse, a patient's relative, or the patient himself request the services of the Social Service Department. When a referral is made, it is expected that a medical social worker will endeavor, whenever possible, not only to help the patient with meeting the need for which he was referred, but to understand the patient as a person and to understand the implications which the experience of having carcinoma has for him. After gaining an understanding of the individual patient and the

particular problems his illness presents to him, a medical social worker tries to help the patient to understand his situation and to do something constructive about it. This may involve advising the patient of the most appropriate resources available for meeting his particular needs and/or helping him to be able to accept the need for the resources and to use these resources most effectively.

Since the social and emotional needs of a patient and those of members of his immediate family each affect the other, a medical caseworker's effort frequently must be directed toward helping both the patient and his family with their respective environmental and emotional problems. Because of the intense emotional impact that the diagnosis of carcinoma holds for members of the patient's family, the understanding, interpretation of the patient's condition and needs, help in working through feelings, and assistance in planning offered by a skilled medical caseworker are particularly valuable in helping the relatives function as effectively as possible for both the patient's and their own well-being.

The Social Service Department's consultation sheets regarding the forty-eight patients included in the study group were carefully studied by the use of Section VI A of the schedule[6] and the various types of assistance offered to the patients and/or members of their families were classified as

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6 See Appendix, p. 104.

TABLE XVII

SERVICES OFFERED TOWARD MEETING THE MEDICAL-SOCIAL NEEDS OF THE PATIENT GROUP

Service Offered	Number
1. Services Related to Arranging for Physical Care - - -	49
a. Follow-up regarding continuing treatment	2
b. Participation in making convalescent home arrangements	2
c. Participation in making nursing home arrangements	14
d. Participation in making arrangements for terminal hospital care	9
e. Participation in plans for transfer to another hospital	3
f. Aid in making plans for home care	19
2. Services Related to Financial Problems - - - - - - - - -	34
a. Participation in referral for financial assistance	8
b. Referral to Public Welfare for adjustment in grant	7
c. Use of Social Service Department funds	5
d. Aid in securing or retaining employment	2
e. Arrangements for transportation to clinic	6
f. Arrangements for transportation to place of resident care	4
g. Referrals to admitting office for plan for payment of hospital bill or clinic fee	2
3. Services Related to Emotional Needs - - - - - - - - - - -	42
a. Interpretation to patient regarding physical condition, medical treatment and/or recommendations for care	6
b. Supportive casework therapy	26
c. Casework therapy directed toward working through one or more problems and toward accepting medical recommendations, treatment, or post-operative status	9

(Continued on next page)

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Service Offered	Number
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f. Aid in making plans for home care	19
2. Services Related to Financial Problems	34
a. Participation in referral for financial assistance	8
b. Referral to Public Welfare for adjustment in grant	7
c. Use of Social Service Department funds	8
d. Aid in securing or retaining employment	2
e. Arrangements for transportation to clinic	8
f. Arrangements for transportation to place of resident care	4
g. Referrals to admitting office for plan for payment of hospital bill or clinic fee	2
3. Services Related to Emotional Needs	42
a. Interpretation to patient regarding physical condition, medical treatment and/or recommendations for care	8
b. Supportive casework therapy	26
c. Casework therapy directed toward working through one or more problems and toward accepting medical recommendations, treatment, or post-operative status	8

(Continued on next page)

TABLE XVII (CONTINUED)

Service Offered		Number
d. Referred for psychiatric treatment	1	
4. Services Related to Needs of Members of Patients' Families -		45
a. Aid in Planning	14	
b. Supportive casework therapy	20	
c. Casework therapy directed toward working through one or more problems and toward accepting the patient's illness and recommendation for the patient's care	6	
d. Referral to another agency	2	
e. Assistance in making plans for care for members of the patient's family	3	
Grand Total of All Services		170

presented in Table XVII. The recorded material indicates a total of one hundred and seventy services offered by medical caseworkers toward meeting medical-social needs of the forty-eight patients and/or members of their families.

As will be indicated in the discussion of limitations to services, a number of the patient's needs could not be met or could only be partially met. The fact that the number of case-work services offered, 170, exceeds the number of recognized medical-social needs, 155, can be explained by the fact that a number of separately listed services were sometimes employed in an effort to meet one need.

TABLE XVII (CONTINUED)

Service Offered	Number
d. Referred for psychiatric treatment	1
4. Services Related to Needs of Members of Patients' Families	45
a. Aid in Planning	14
b. Supportive casework therapy	20
c. Casework therapy directed toward working through one or more problems and toward accepting the patient's illness and recommendation for the patient's care	8
d. Referral to another agency	2
e. Assistance in making plans for care for members of the patient's family	3
Grand Total of All Services	170

A total of forty-nine services were directed toward helping forty-one patients in making arrangements for one or more types of physical care. The listing of these services as appears in Section 1 of Table XVII seems to be self-explanatory except for item (f)--"aid in making plans for home care". The nineteen services given in this area were made up of a total of twenty-two arrangements, as under the classification title were included: (1) referrals to the Visiting Nurses Association, (2) participation inplanning for a housekeeper or nurse's services, and (3) explaining the patient's need for physical care to members of the patient's family.

Twenty-five patients needed a total of thirty-four services directed toward removing financial limitations preventing each of these patients from receiving or effectively using some needed treatment, service, appliance or care. These services as itemized in Section 2 of Table XVII are considered to be self-explanatory.

A total of forty-two services were employed in an attempt to meet or mitigate the emotional needs of twenty-seven patients. These services are classified as being of three types: (1) interpretation to the patient regarding his physical condition, medical treatment, and/or recommendations for care, (2) Supportive casework therapy, and (3) casework therapy directed toward the patient's working through one or more problems and toward accepting recommendation for specific treatment and/or type of care and post-operative status. The number of patients

who received these various services is shown in Section 3 of Table XVII.

In twenty-five cases, a total of forty-five services were directed toward elimination or mitigation of problems of members of the patients' families which were the limiting or prohibiting factors in relation to the patients' receiving or effectively using the medical treatment or nursing care needed. All of these twenty-five patients received one or more of the following services: (1) aid in planning for the patient's care, (2) supportive casework therapy, (3) casework therapy directed toward working through one or more problems and toward helping the relative to be able to better accept the patient's having carcinoma and to accept recommendations for the patient's care, (4) referral to another agency for specific services, and (5) assistance in making plans for care for members of the patient's family. Information regarding the numerical distribution of these services among the twenty-five patients is recorded in Section 4 of Table XVII.

All but one of the total of forty-eight patients in the study group received assistance with at least one problem. (This one patient died immediately following his doctor's referring his wife to Social Service for assistance in securing blood donors.) The total number of all casework services per patient is shown in TAble XVIII. The arithmetic average of services per patient is 3.5. Seven patients were given only the services for which referral was made, while forty patients

who received these various services is shown in Section 3 of Table XVII.

In twenty-five cases, a total of forty-five services were directed toward elimination or mitigation of problems or weaknesses of the patients' families which were the limiting or prohibiting factors in relation to the patients' receiving or effectively using the medical treatment or nursing care needed. All of these twenty-five patients received one or more of the following services: (1) aid in planning for the patient's care, (2) supportive casework therapy, (3) casework therapy directed toward working through one or more problems and toward helping the relative to be able to better accept the patient's having certain needs and to accept recommendations for the patient's care, (4) referral to another agency for specific services, and (5) assistance in making plans for care for members of the patient's family. Information regarding the numerical distribution of these services among the twenty-five patients is recorded in Section 4 of Table XVII.

All but one of the total of forty-eight patients in the study group received assistance with at least one problem. (This one patient died immediately following his doctor's referring his wife to Social Service for assistance in securing blood donors.) The total number of all casework services per patient is shown in Table XVIII. The arithmetic average of services per patient is 3.5. Seven patients were given only the services for which referral was made, while forty patients

TABLE XVIII

NUMBER OF CASEWORK SERVICES PER PATIENT

Number of Services	No. of Patients	Total Services
None	1	-
One	7	7
Two	8	16
Three	7	21
Four	9	36
Five	8	40
Six	6	36
Seven	2	14
Total	48	170

were found to need and therefore were offered additional services.

Limitations Encountered in Meeting Medical-Social Needs of Patients

The social service recordings regarding the forty-eight patients whose records were used for this study were examined for indications of limitations encountered in meeting the medical-social needs of this patient group. This was done by carefully checking the material assembled on the schedule under "Medical-Social Problems" [7] against the material assembled on

7 See Appendix, pp. 102-103.

Number of Services	No. of Patients	Total Services
None	1	-
One	7	7
Two	8	16
Three	7	21
Four	9	36
Five	8	40
Six	5	35
Seven	2	14
Total	48	170

the schedule under "Services Given" [8] for each of the patients.

In regard to thirty patients, the recorded material on which this study is based gives no indication of limitations to meeting the specified needs of these patients which were related to the patients' receiving and effectively using the recommended medical care and to the patients' making good post treatment adjustment. Indications of one limitation to service were found in the records regarding fifteen of the patients and indications of two limitations to service were found in the records regarding three of the patients.

Eleven, or fifty-two per cent, of the twenty-one factors preventing the adequate fulfillment of some of the patients' needs for medical care can be identified as limitations in resources. The delay of several months in an increase in public welfare grants becoming effective for two patients prevented those patients from following post-operative diets and in both cases prolonged and complicated the convalescent period. The time required for the place of two patients' settlements to be determined for disposition of their applications for Old Age Assistance delayed transferring these two patients to a terminal care hospital and contributed to the anxiety of both the patients and their families. For seven cases the limitation in resources was the limited availability of licensed nursing homes which would accept carcinoma patients

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8 See Appendix, p. 104.

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8 See Appendix, p. 104.

at a rate that could be met by an Old Age Assistance grant or by a patient (or his family) in modest circumstances. Because of the unavailability of a Jewish nursing home which would accept a patient at a rate that could be paid by an Old Age Assistance grant, it was necessary for a Hebrew patient to go to a non-Jewish home in which he was unable to make a good adjustment.

In three cases the patient's personality was the factor limiting the effectiveness of casework services in meeting the patient's medical-social needs. One of these patients lived alone for one year following recommendations for nursing home care or housekeeping services before she could accept the dependency role implied in receiving Old Age Assistance. Another patient was emotionally unable to remain in a terminal care hospital although she could receive little or no care in her home. The third patient was emotionally unable to effectively plan for treatment because of her concern about her emotionally immature adult son who lived with her.

In seven instances, the personality of a member of the patient's family precluded the patient from either having or effectively using adequate care or treatment. The social service recordings indicated that four wives seemed both emotionally unable to give consent for their husbands to enter a nursing home or to give them adequate care at home although casework was directed toward helping them in these areas. The emotionally immature adult son of one patient was unable to

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accept his mother's absence from the home for the purpose of receiving active treatment in the hospital and prevented her from receiving recommended treatment by making threats concerning what he would do if she entered the hospital again. The mother and sister of one patient contributed to the anxiety of the patient and placed certain limitations on plans for nursing home care by their rejection of her. The friction among her six children seemed to be the chief factor contributing to one patient's inability to remain in a resident care home.

Approved,

Richard K. Conant
Dean

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CHAPTER V

CASE PRESENTATIONS

From the forty-eight cases studied, six have been selected for presentation. The factors determining the selection were two: (1) cases on which sufficient material was available for narrative presentation, and (2) cases which would illustrate the widest range of problems and casework treatment procedures.

Case I

In March, 1947, Mary McAdams, a fifty-nine year old single woman who was employed as a ward maid at another hospital, came to the Peter Bent Brigham Hospital Out-Patient Department for examination which was prompted by a symptomatology of two and one-half years duration. As the clinic examination indicated the possibility of cancer of the ovaries immediate hospitalization was recommended. Further examination revealed that the patient had adenocarcinoma of both ovaries and a bilateral salpingo-oophorectomy was performed.

When surgery was recommended, Miss McAdams was referred to the Social Service Department by her attending physician because of her concern about plans for her convalescent period. Prior to her hospitalization, Miss McAdams had lived in a maids' dormitory at the hospital in which she had been employed and she had no living relatives. The patient had a small savings account but was afraid that it would not be sufficient to meet her expenses in a convalescent home until such time as she would be able to return to work.

Miss McAdams was assisted in making plans to enter the St. Luke's Convalescent Home where

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Case I

arrangements for her to pay ten dollars a week were in keeping with her financial limitations but allowed the patient to feel that she was maintaining her independence. The patient was also assisted in making satisfactory plans for her transportation to the hospital for her daily X-ray treatments.

On her twenty-third hospital day, Miss McAdams was discharged to the convalescent home where she remained for about a month prior to returning to her former employment.

Comment. The Social Service Department's recordings indicate that Miss McAdams seemed to be a capable and mature individual. This case seems therefore to exemplify the manner in which patients who seem to present no spectacular social problems need and can use certain services offered by medical social workers.

Miss McAdams welcomed the social worker's visits and expressed to the worker fears about her forthcoming operation, feelings regarding her having no living relatives, and concern about her future and her entire security. With evidences of the worker's interest in her, the patient felt less alone, was able, with the worker's help to explore some of her fears and to make plans for her convalexcent care, transportation to the hospital for continued treatment and reemployment.

Case II

Margaret O'Malley, sixty-five year old childless widow, was referred to the Social Service Department by the examining physician when she had not accepted the recommendations for immediate

arrangements for her to pay ten dollars a week were in keeping with her financial limitations but allowed the patient to feel that she was maintaining her independence. The patient was also assisted in making satisfactory plans for her transportation to the hospital for her daily X-ray treatments.

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Case II

Margaret O'Malley, sixty-five year old child-less widow, was referred to the Social Service Department by the examining physician when she had not accepted the recommendations for immediate

hospitalization and surgery made by the physicians in the Tumor-Neuro Clinic where she was examined on February 1, 1947. Mrs. O'Malley had had a right radical masectomy eleven years prior and now examination disclosed a mass in the left breast.

The medical caseworker made ahome visit to see Mrs. O'Malley. The patient, who lived with a widowed niece, was employed at a factory. In speaking of her work, Mrs. O'Malley indicated that she enjoyed it and showed considerable pride as she told that she was considered to be a good worker and had not been dismissed, as many were, when the factory reconverted to peacetime activities.

Mrs. O'Malley knew her diagnosis and readily agreed that she should enter the hospital immediately for a left mastectomy but told that she was afraid. She told that she had experienced considerable pain following the right mastectomy and that since that operation she had not been able to sleep comfortably on her right side. She expressed fears related to her being dependent on others for an indefinite period for such little things as having her hair combed. The patient told that she had Blue Cross coverage and that she had an insurance policy that would pay her benefits of fourteen dollars a week for thirteen weeks during such a period as she was unable to work because of illness, but she verbalized fear of economic dependence if she should be unable to return to work. Mrs. O'Malley's general feeling of insecurity regarding the future was revealed in her explanation that although she had lived with her niece for some time and enjoyed this living arrangement, she was maintaining a rented room in Boston so that should she need to apply for Old Age Assistance, her situation could be considered apart from that of her niece.

After discussing her fears regarding having the operation and those regarding not having the operation, Mrs. O'Malley said that she would plan to enter the hospital on March 11. She explained that she had a number of social affairs planned for the month and that she would like to participate in and enjoy these prior to having the

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operation as she felt that her activities would be limited for a period following the operation.

The hospital record regarding this patient shows that she entered the hospital on March 11, 1947, and underwent the advised radical left mastectomy. The clinic record of Mrs. O'Malley's post-operative care following her discharge from the hospital indicated that the patient's prognosis was considered to be good and that she was able to return to her employment within a comparatively short time.

Comment. This very active sixty-five year old woman, who for the second time was having to face the advisability of a mutilating operation, was already besieged by fears and insecurities related to her age and having no one on whom she could accept being dependent. During one visit with this patient, the medical caseworker was able to help Mrs. O'Malley to face her medical problem realistically and to be able to accept the recommendations for the treatment so essential to her future good health. The worker, by expressing an understanding of Mrs. O'Malley's fears and feelings, offered the patient the supportive help she needed in making the difficult decision to have the operation. Although it had been hoped that Mrs. O'Malley would plan to enter the hospital immediately, the worker accepted the patient's own plan to come in in six weeks. The worker felt that the patient's participation in the social activities she had planned would help the patient to be able to marshal her strengths toward accepting her post-operative state and to function most effectively in it.

No information is available regarding further visits with

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No information is available regarding further visits with

the patient although the social service consultation sheet recording indicated the worker's plans to see the patient when she entered the hospital. Generally such an absence of further notations is indicative of no further significant developments in the case. The purpose for which the referral of this case had been made was accomplished with the patient's entering the hospital.

CASE III

Mary Callahan, a thirty-seven year old married woman with children whose ages ranged from fourteen to two years, was referred to the Social Service Department by the head nurse on the hospital ward on which Mrs. Callahan was a patient. The referral was made with recommendations for family planning as the patient had expressed concern about her ability to manage her home under her medical restrictions. The patient's diagnosis was postoperative carcinoma of the right breast, with multiple metastasis. The prognosis for Mrs. Callahan was for a very short life expectancy.

Mrs. Callahan was seen by a medical social worker several times while the patient was in the hospital and frequently following her tri-weekly clinic visits during the ensuing three months. Mr. Callahan was also seen periodically from the time the case was referred.

Environmental problems recognized during the period that the patient and her husband were known to Social Service included a need for housekeeping services and the financial inability to pay for housekeeping services, X-ray treatments, certain injections, a brace, a corset, and terminal care.

Both the patient and her husband were under intense emotional strain. Mrs. Callahan had not been told of her diagnosis until about ten days before she entered a terminal care hospital when her husband, unable to bear the strain of protect-

ing her from the knowledge of her diagnosis and prognosis any longer, told her that she had carcinoma and would not recover. The fact that the patient had been unable to tell the doctor that a member of her family, her mother, had died of cancer, until after her husband had told her that she had cancer, is just one of several evidences that this patient was aware of her diagnosis when she entered the Peter Bent Brigham Hospital and gave the family history data. Throughout the period, the patient was seen by the social worker and although in severe pain, Mrs. Callahan displayed emotional stability. The patient told the doctors and the social worker of her physical suffering but she tried to protect her husband and children from seeing any indication of her discomfort. The patient stated that she wanted to remain with her family until her pain became intolerable and then she wanted to enter a terminal care hospital where her husband and children would not have to witness her suffering and she followed this plan. After the patient was told of her diagnosis and prognosis she was able to plan with the family agency, to which the family had already been referred for housekeeping services, about plans for the children's care after her death. During her interviews with the worker, in addition to discussing the need for certain services, medication, and appliances, Mrs. Callahan discussed her feelings about her illness, her pain, and death.

Mr. Callahan discussed the various plans for his wife's care with the worker but asked the worker to make most of the arrangements as he acknowledged that it took all the strength he had to keep from crying every time he looked at his wife. To the worker, Mr. Callahan expressed his feelings about his wife's condition, about his bewilderment in knowing what he would do after her demise, and about his being unable to pay for all of things she had needed.

The worker referred Mr. and Mrs. Callahan to three appropriate welfare agencies and to the Holy Ghost Hospital at the indicated time. By helping the patient and her husband to accept these referrals and by making them, the worker helped Mr. and Mrs. Callahan in securing the services, medication, appliances, and care the

patient needed to be as comfortable and as free from anxiety as possible during the last few months of her illness.

Comment. The services the social worker gave to Mrs. and Mr. Callahan during the three month period immediately prior to Mrs. Callahan's entering Holy Ghost Hospital represent an integration of the processes of making environmental adjustments, of giving emotional support and of helping the patient and her husband work through their feelings about the patient's physical status. To give such services, it was necessary for the worker to know of appropriate resources, to anticipate the needs, and to help the patient and her husband in being able to use the resources that could provide those things that would facilitate the patient's having adequate care and the family's having services appropriate to maintaining family unity and as much freedom from anxiety as possible. The environmental adjustments facilitated by the social worker made available to Mrs. Callahan the medication, treatment, and care which composed an adequate medical plan for this patient. By the application of casework therapy in meeting some of the patient's and her husband's emotional needs, the worker helped the patient to be emotionally free to effectively use the resources for her care.

Case IV

Saul Greenberg, who was seventy-two years of age as of 1947, was first admitted to the Peter Bent Brigham Hospital in December, 1945, and was

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from anxiety as possible during the last few
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Case IV

Carl Greenberg, who was seventy-two years of age as of 1947, was first admitted to the Peter Bent Brigham Hospital in December, 1945, and was

diagnosed as having carcinoma of the sigmoid. During the year of 1946 the patient underwent three operative procedures including the excision of a colostomy and the closure of the colostomy. During 1947 the patient was hospitalized for three periods, a total of one hundred and sixteen days. The diagnosis regarding malignancy was metastatic carcinoma of the right lung and postoperative carcinoma of the sigmoid. The prognosis was for a short life expectancy.

Mr. Greenberg was first referred to the Social Service Department just prior to his discharge from his last 1947 hospitalization. The referral was a request for a caseworker to assist the patient and his family in making plans for the patient to enter a nursing home. Neither the patient nor his wife was able to accept plans for Mr. Greenberg's going to a nursing home at the time of his discharge. The worker, therefore, assisted in making plans with Mrs. Greenberg for the patient's care at home by making a referral to the Visiting Nurses Association and interpreting the patient's need for care to the patient. Mrs. Greenberg, who was in poor health herself, seemed unable to accept the fact that her husband's condition was critical and that he would not recover, until after she had attempted to care for him and witnessed his progressively worse condition. During the period the patient remained in his own home, the worker made several recommendations to the Old Age Assistance office for allowances in Mr. Greenberg's grant for medications, appliances, and diets. Six months after the patient's discharge from the hospital both the patient and his wife recognized the need for the patient to go into a nursing home. The worker with the cooperation of an Old Age Assistance visitor helped the patient's wife to make arrangements for nursing home care for Mr. Greenberg. A few months after the patient was established in a nursing home, Mrs. Greenberg discussed with the worker her husband's need for more care. The worker then assisted Mrs. Greenberg in making plans for Mr. Greenberg to enter the Jewish Memorial Hospital for terminal care.

Comment. Although the recorded material regarding this case gave comparatively little information about the emotional

aspects of the case, it illustrates a continuous process of adjusting the environment to meet the current situation. Evidence is given of the worker's helping the patient and his wife in making an effective as possible plan for Mr. Greenberg's care at home when Mr. and Mrs. Greenberg were, for a time, emotionally unable to accept the recommendations for nursing home care.

Case V

Muriel Mott, a twenty-eight year old single night-club entertainer, entered the hospital as an emergency patient. The diagnosis was carcinoma of the cervix with local extension involving both ureters and the rectum. Five months before this admission, Miss Mott had undergone three surgical procedures including a radical hysterectomy elsewhere. The patient was kept in the Peter Bent Brigham Hospital for one hundred and thirty-two days and during this period was given X-ray treatment.

For the previous eight years the patient, a white woman, had been keeping company with a married Negro man, Mr. Smith. This man was the putative father of a child to which she gave normal birth and was allegedly responsible for two other pregnancies that were culminated by abortions. The patient's close relatives consisted of her mother and three siblings but she was not accepted by these relatives because of her married Negro friend. During the long period of hospitalization, the patient's mother and sister visited her occasionally but continued their condemnation of her. Miss Mott told that during the eight years she had been dating Mr. Smith, she had given up her white friends and moved to a Negro neighborhood to live in the same boarding house as Mr. Smith. She also related that she and Mr. Smith would have married if his wife had not refused to give him a divorce.

Miss Mott was referred to Social Service several weeks prior to her being discharged from the hospital for aid in making discharge plans. The patient wanted to return to the boarding house where she had been living. The worker talked with Mr. Smith who understood how impossible caring for the patient in her room would be and who helped the patient to accept nursing home plans. Both the patient and Mr. Smith preferred a Negro nursing home or one accepting both white and Negro patients. The worker made arrangements for Mr. Smith to visit several homes after which he and the patient made the selection. Mr. Smith paid the larger part of the patient's board in the nursing home but because of his inability to assume the entire responsibility for payment when the patient's sister discontinued contributing, Miss Mott was referred to Public Welfare. Before the plans for Public Welfare were completed, the patient died.

During several of the interviews the worker had with Miss Mott while she was in the hospital, the patient expressed some of her feelings regarding being responsible for her condition because of having had the abortions.

Comment. In this case the social-medical problems related to the patient's illness are superimposed upon preexisting social problems. This case illustrates, perhaps in an exaggerated way, the significance of the site of a malignant growth.

In this case all of the medical-social needs of the patient related to receiving the care she needed were met. The casework services consisted of supportive therapy for both the patient and her friend, assistance to the friend in making the nursing home arrangements and referral to Public Welfare for partial payment of the patient's nursing home care.

Case VI

Juanita Lewis, a forty-eight year old divorced Negro woman, had been under active treatment for carcinoma of the cervix for several years. Her diagnosis in 1947 was post-irradiation carcinoma of the cervix. As a result of the treatment, Mrs. Lewis had a colostomy. Her prognosis was good.

Mrs. Lewis was referred to Social Service at the time of discharge. The recommendation in the referral which was made by the patient's physician was for aiding the patient in finding employment.

The patient had an intense feeling of shame regarding her colostomy over which she did not have too good control when she was not in the hospital. Mrs. Lewis had not been able to follow her diet carefully because of her limited finances, a public welfare grant. Recommendations were made for Public Welfare to provide an allocation for the special diet, and the diet and its importance was interpreted to the patient.

When Mrs. Lewis' colostomy was controlled, possibilities of employment were considered. The patient expressed a desire to return to the place of her employment as a maid. Arrangements were made for her to return to the job she had immediately prior to her illness but the patient was emotionally unable to report for the work. The worker continued to see the patient over a period of a year with the treatment being directed toward helping Mrs. Lewis work through her feelings and fears about her colostomy. Arrangements were then made, with Mrs. Lewis' participation, for her to work in one of the hospital kitchens as a maid. The patient was able to accept employment in the protective environment of the hospital and made a good adjustment in this work.

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Comment. The case of Mrs. Lewis illustrates some of the problems of personal adjustment that patients who undergo mutilating operations must face. Mrs. Lewis had considerable difficulty in being able to work through the intense feeling

of shame which she had in regard to her colostomy and which blocked her from associating with people. With the aid of a sympathetic social worker who employed the use of several appropriate environmental manipulations and who helped the patient work through some of her intense feelings about her condition, Mrs. Lewis was able to accept and make a good adjustment to a job in a protective environment.

CHAPTER VI

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

Because of the apparent frequency and severity of the social and emotional implications of carcinoma for patients with this disease, and because of the relatively large number of people whose security and lives are affected by the disease--either by being a victim or by being a member of the family of a victim of the disease--this study has been directed toward achieving a better understanding of the social and emotional needs of cancer patients. For the purpose of arriving at a better understanding of these needs, the medical and social service records regarding forty-eight patients with a diagnosis of carcinoma were studied. This group represents the total of those patients hospitalized for treatment of a cancerous condition at the Peter Bent Brigham Hospital during the year of 1947 who were referred to the Social Service Department and on whom sufficient information for study was available.

The study of these cases was focused upon an attempt to answer the three questions posed in the introductory chapter[1]

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and which are:

1. Why were these carcinoma patients referred to the social worker, and, if by the doctor, with what recommendation?
2. What are the social and emotional needs as shown by a study of the social service and medical records of these carcinoma patients?
3. What factors limited the social worker's ability to meet the need for which the referral was made and the additional recognized needs of each patient?

The study disclosed that the referrals to the Social Service Department were made by a physician or nurse in all but two of the forty-eight cases. In about sixty-nine per cent of the cases the referrals were made with recommendations concerning specific arrangements deemed necessary to facilitate the patient's following medical recommendations or in making a good post-treatment adjustment. The remaining thirty-one per cent of the patients included in the study group were referred for social study to determine how these patients' needs for treatment and special care could be met most effectively.

A study of the recorded material regarding the forty-eight patients revealed the presence of a total of one hundred and fifty-five medical-social problems. The range in number

of recognized problems per patient was one to seven. Both the arithmetic average and the median of the number of problems per patient were three. In forty-five cases there are indications of a total of fifty-two needs for arrangements being made for the patients' physical care, that is, for further treatment and/or convalescent, nursing, or terminal care. Evidences of a total of forty-seven financial problems affecting planning for one or more categories of the patients' need for care were found in the recorded material for thirty-nine patients. Although the brevity of the available records does not permit a complete evaluation of the emotional problems of the patient and members of his family which were precipitated by the illness and/or which affected planning for the patient's treatment and care, evidences of a number of such problems were found in the recorded material. Emotional symptoms presented by twenty patients seemed to have been precipitated by the illness itself or an operation performed in treatment of the malignancy. For nine patients emotional problems existing prior to illness seemed to be active factors in limiting the ways in which these patients could use available treatment and care. Information included in the records regarding twenty-five patients revealed a total of twenty-seven problems in the family situations which affected planning for the patients' treatment and care. In twenty-one of these twenty-five cases the recognized problem was of an emotional nature and was related to a member of the

patient's family accepting the patient's illness and the recommendations for his care. In three situations there was a need for aid in planning for the care of members of the patients' families. In three other cases the disinterest in the patient of members of the patient's family posed a problem.

Conclusions

The consideration of the social and emotional implications of the disease carcinoma and a study of the social service recording on forty-eight carcinoma patients reveals that patients with this disease are frequently subject to many and intense physical, environmental, and emotional stresses during the course of their illness. Of the various diseases to which mankind is subject, carcinoma is one of, if not the most threatening to personal security. The nature of the disease and the radical procedures usually involved in adequate treatment contribute to the many and varied social and emotional needs experienced by patients with cancer.

Carcinoma patients need adequate facilities for diagnosis, treatment, and care. To have a reasonable chance of being successfully treated, their malignancies must be diagnosed and treated while the growths are relatively small and are localized. Cancer patients frequently need hospitalization for the purpose of early diagnosis as well as for active and palliative

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treatment. Medical supervision is needed for an extended period, and, even when the diagnosis and treatment are secured early and the prognosis is good, follow-up care is indicated. Post-operative patients, in addition to needing follow-up care, may need special care at home or in a convalescent home following discharge from the hospital. The needs for physical attention of those carcinoma patients whose conditions are untreatable range from a need for members of their household to be instructed in methods of home care and/or a need for a visiting nurse's services to the need for the services of full time nurses or the need for the patient to enter a nursing home or terminal care hospital. In all but three of the forty-eight cases studied, one or more problems directly related to making arrangements for the needed physical care were found to have existed.

Carcinoma is an incapacitating disease and a disease for which treatment and care are expensive, and continue over an extended period, therefore, it is not surprising that carcinoma patients frequently are confronted with financial problems. Fulfillment of patients' medical needs may intensify or precipitate financial problems, or the lack of financial security may serve as a barrier to the patients' entering or continuing in treatment. Although the records on the patient group studied indicated that thirty-three of the forty-eight patients were entirely self-supporting at the time of their first 1947 hospital admission, during the course of their treatment

thirty-nine were known to have had financial problems which affected planning for their care aside from paying for their hospital care.

Emotional problems of cancer patients merit consideration both from the standpoint of being precipitated by the many traumatic consequences of the disease and from the standpoint of being a barrier to securing and effectively using the needed treatment and care. A multitude of emotions are precipitated by any illness and treatment procedure. Like patients with other chronic diseases, carcinoma patients may have anxieties about subsistence for themselves and their dependents, about possible loss of prestige because of their physical disability and their dependency. But, in addition to these sources of anxiety, the patient with cancer faces other threatening possibilities. To the patient with a malignant growth, an abrupt and painful death is a real possibility. Often the only effective treatment of the disease is a mutilating operation which leaves the patient with a permanent disability or disfigurement. The carcinoma patient, frequently besieged by many fears (some rooted in reality factors of the nature of the disease and of its treatment, and others partially rooted in ignorance of the nature and treatability of the disease) is faced with the necessity for making many personal adjustments.

Problems of an emotional nature precipitated or reactivated by the illness and the treatment procedures as well as

emotional problems existent prior to the illness, unless mitigated, can serve as a barrier to the patient's making the many personal adjustments necessary to his obtaining and effectively using the needed treatment and care facilities. In this disease for which adequate treatment and care are so important to the patient's recovery or comfort, the need for a recognition and understanding of the patient's emotional problems should be a challenge to those responsible for the supervision of their care.

A consideration of the recordings regarding the forty-eight patients in the study group bears out the frequency of occurrence and significance of emotional problems of carcinoma patients in that twenty-nine of the thirty patients who were not too ill to be interviewed by a social worker presented symptoms of emotional problems which affected planning for their medical treatment and care.

Adequate treatment and care for a carcinoma patient can be blocked or disastrously delayed by the patient's family responsibilities and by the attitudes of members of the patient's family toward him and his illness and their understanding of the illness. Just as carcinoma frequently presents many threatening aspects for the patient and at the same time requires his making many personal adjustments, the patient's illness often elicits feelings of fear, guilt, and frustration in members of his family at the same time that the need arises for them to assume additional responsibilities and make

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A consideration of the recordings regarding the forty-eight patients in the study group bears out the frequency of occurrence and significance of emotional problems of certain patients in that twenty-nine of the thirty patients who were not too ill to be interviewed by a social worker presented symptoms of emotional problems which affected planning for their medical treatment and care.

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certain adjustments.

Recommendations

This study points toward a need for intensive research regarding the social and emotional needs of carcinoma patients and regarding the most efficient and effective methods by which these needs can be met. Such research seems to be necessary if the apparent current lag of understanding of the social and emotional implications of cancer for the individual patient behind the understanding of the nature of the disease itself is to be overcome. Unless steps are taken to make possible an understanding of the individual with cancer, the recent trend in medicine pointing away from the treatment of a disease and toward the treatment of the individual with the disease will not be reflected in the medical treatment of the cancer patients.

Toward the elimination of the above-mentioned lag, the writer makes the following recommendations:

1. That Social Service Departments in hospitals and clinics that treat cancer patients make provisions, wherever possible, for each carcinoma patient for whom the prognosis is poor or for whom some major type of treatment has been advised to be interviewed by a medical social worker.

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1. That Social Service Departments in hospitals and clinics that treat cancer patients make provisions, wherever possible, for each cancerous patient for whom the prognosis is poor or for whom some major type of treatment has been advised to be interviewed by a medical social worker.

2. That medical social workers consider the social and emotional needs of cancer patients as carefully and objectively as possible and report their observations and techniques of treatment.
3. That some attention be directed toward the education of the general public regarding some of the social and emotional needs of cancer patients.
4. That publicity be given to the need for the availability of more nursing home facilities for carcinoma patients at low and moderate costs.

Approved,

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APPENDIX

THE NEEDS OF HOSPITALIZED MALIGNANT TUMOR PATIENTS AS EVIDENCED BY A STUDY OF THE USE OF SOCIAL SERVICE

Peter Bent Brigham Hospital, year of 1947

I. Identifying Information

Name _____ Record Nos: House _____ O.P.D.__ S.S.D__

Age _____ Sex _____ Color _____ Religion _____

Citizen _____ Marital Status _____ Occupation _____

Address by City _____

II. Medical Information

A. Related to 1947 hospitalizations

Number of 1947 admissions at P.B.B.H. _____

Date of each 1947 admission: 1st ____ 2nd ____ 3rd ____

Date of each discharge from a 1947 admission: 1st ____ 2nd ____ 3rd ____

Diagnosis: 1st admission _____

_____

2nd admission _____

_____

3rd admission _____

_____

Operations performed:

1st admission _____

_____

2nd admission _____

_____

3rd admission _____

_____

THE NEEDS OF HOSPITALIZED MALIGNANT TUMOR PATIENTS AS
EVIDENCED BY A STUDY OF THE RECORDS OF [illegible]

Peter Bent Brigham Hospital, year of 1947

Condition on discharge:

1st 1947 hospitalization: Improved ___

No improvement _____

Deceased _____

2nd 1947 hospitalization: Improved _____

No improvement _____

Deceased _____

3rd 1947 hospitalization: Improved _____

No improvement _____

Deceased _____

Degree of disability at discharge:

1st 1947 hospitalization:

Able to return to usual pursuits _____.
Some changes in usual activities _____.
Ambulatory but limited regime _____.
Chair and bed _____.
Bed _____.

2nd 1947 hospitalization:

Able to return to usual pursuits _____.
Some changes in usual activities _____.
Ambulatory but limited regime _____.
Chair and bed _____.
Bed _____.

3rd 1947 hospitalization:

Able to return to usual pursuits _____.
Some changes in usual activities _____.
Ambulatory but limited regime _____.
Chair and bed _____.
Bed _____.

Prognosis at discharge _____.

Follow-up care:

Following discharge from 1st 1947 hospitalization:

By private doctor ___. By P.B.B.O.P.D. ___ Other _____ (Specify)

Following discharge from 2nd 1947 hospitalization:

By private doctor ___. By P.B.B.O.P.D. ___ Other _____ (Specify)

Following discharge from 3rd 1947 hospitalization:

By private doctor ___. By P.B.B.O.P.D. ___ Other _____ (Specify)

B. Previous Medical Care Related to Diagnosis of Malignant Tumor:

Date of 1st diagnosis of malignant tumor _____.

Period of active treatment for malignant tumor _____.

Number of operations related to diagnosis of malignant tumor (other than 1947 operations) _____.

Other treatment for malignant tumor:

Types: _____ _____ _____

Periods of above treatment: _____ _____ _____

C. Previous Acknowledged Hospitalizations:

Year	No. of Days	P.B.B.H.	Other	Related to Malig. Tumor	Related to other diagnosis

Follow-up care:

Following discharge from 1st 1947 hospitalization:

By private doctor ___. By P.B.H.O.P.D. ___ Other _____ (Specify)

Following discharge from 2nd 1947 hospitalization:

By private doctor ___. By P.B.H.O.P.D. ___ Other _____ (Specify)

Following discharge from 3rd 1947 hospitalization:

By private doctor ___. By P.B.H.O.P.D. ___ Other _____ (Specify)

B. Previous Medical Care Related to Diagnosis of Malignant Tumor:

Date of 1st diagnosis of malignant tumor _____.

Period of active treatment for malignant tumor _____.

Number of operations related to diagnosis of malignant tumor (other than 1947 operations) _____.

Other treatment for malignant tumor:

Type: _____ _____ _____

Periods of above treatment: _____ _____ _____

C. Previous Acknowledged Hospitalizations:

Year	No. of Days	P.B.H.	Other	Malig. Tumor	Related to other diagnosis

III. Referrals to Social Service

Source of _____ Date of _____

Reason for _____

IV. Social Information

Mode of living prior to hospitalization:

Alone _____. Parent _____. Spouse _____.

Children (without spouse) _____. Other relatives ____

Institution (specify) _____. Elsewhere (specify) _____

Composition of household: _____.

_____.

Members of family outside household: _____

_____.

Source of income at time of hospital admission:

Self-supporting: _____.

Dependent on relatives: (a) In the home _____.
(b) Outside of home _____.

Relief (specify) _____. Other (specify) _____.

V. Medical Social Problems

A. Problems Related to Physical Care: _____

III. Referrals to Social Service

Source of _____ Date of _____

Reason for _____

IV. Social Information

Mode of living prior to hospitalization:

Alone ____. Parent ____. Spouse ____.

Children (without spouse) ____. Other relatives ____

Institution (specify) _____. Elsewhere (specify) _____

Composition of household: _____.

_____.

Members of family outside household: _____

_____.

Source of income at time of hospital admission:

Self-supporting: ____.

Dependent on relatives: (a) In the home _____.
(b) Outside of home _____.

Relief (specify) _____. Other (specify) _____.

V. Medical Social Problems

A. Problems Related to Physical Care: _____

_____

_____

_____

_____

_____

_____

_____

B. Financial Problems: _____

C. Problems of an Emotional Nature: _____

D. Problems Related to Securing Special Services: _____

E. Problems of Members of Patient's Family (as related to patient's illness): _____

VI. Treatment of Medical-Social Problems.

A. Services Given: _____

B. Limitations to Service: _____